

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4-2

## CERTIFICATE OF DEATH

05500

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County... AlleganyCity or town... Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs

Hospital, institution, or street address where death occurred:

326 Front

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Ma. County... AlleganyCity or town... Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 Front

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Moses Lorenza Dow Albright

## 3. (b) Social Security Number

213-01-9025

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife... Sara Albright6. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) Oct 27, 1872

8. AGE: Years Months Days If less than one day

73717

hrs. min.

9. Birthplace... Augusta-Hampshire-W.Va.

(Town, county, and state)

10. Usual occupation... Clerk11. Industry or business... Clothing Store12. Name... Samuel Albright13. Birthplace... W.Va.14. Maiden name... Mary Ellen Shanks15. Birthplace... W.Va.16. Informant... Mrs. Dow AlbrightAddress... 326 Front St. Westernport, Md.17. Burial... Date thereof... June 17, 46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory... philosLocation... Westernport, Md.18. Funeral director... Ellsworth S. RoalAddress... Westernport, Md.19. June 17, 46 Date rec'd by registrar

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 14, 1946 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 1, 1946 to June 14, 1946and that I last saw him alive on June 14, 1946

Immediate cause of death

Carcinoma -metastatic colon

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

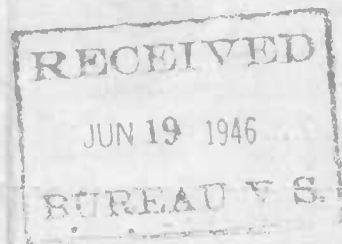
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

Address... Westernport, Md. Date signed 6/17/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05501

Reg. Dist. No. 1

## 1. PLACE OF DEATH:

County Allegany  
 City or town Oldtown, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Oldtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

William C Alderton

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mary L  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 1872  
 8. AGE: Years 73 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Green Ridge, Md.  
 (Town, county, and state)  
 10. Usual occupation Mail Carrier  
 11. Industry or business U.S. Government  
 12. Name Peter Alderton  
 13. Birthplace Md.  
 14. Maiden name Maizie Slides  
 15. Birthplace Md.

16. Informant Mrs William C Alderton  
 Address Oldtown, Md.  
 17. Burial Date thereof June 27, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Oldtown, Md.  
 Location Oldtown, Md.  
 18. Funeral director James L. Steen, Inc.  
 Address Cumberland, Md.

19. June 26 1946 Mrs L.A. Shamholz  
 Date rec'd by registrar Registrar Address

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1946 at 2:16 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 15, 1946 to June 24, 1946  
 and that I last saw him alive on June 22, 1946  
 Immediate cause of death uraemia  
 Due to Generalized arteriosclerosis - 5 yrs  
 Due to Chronic Nephritis - 5 yrs  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Clayton James  
 M. D. or other \_\_\_\_\_  
 Address Cumberland, Md. Date signed June 24, 1946

RECEIVED  
JUL 1 1946  
BUREAU V.S.



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY  
City or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL  
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... MARYLAND County... ALLEGANY  
City or town... MT. SAVAGE  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. MINNIE ALDRIDGE

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife... HOWARD ALDRIDGE

7. Birth date of deceased (mo., day, yr.) FEB. 6, 1887 8. (c) If alive, give age 71 years

8. AGE: Years 59 Months 2 Days 6 If less than one day  
hrs. min.

9. Birthplace... MARYLAND  
(Town, county, and state)

10. Usual occupation... HOUSEWIFE

11. Industry or business

12. Name WILLIAM POLLOCK  
13. Birthplace GERMANY

14. Maiden name MARY SCHUTZ  
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL  
Address CUMBERLAND, MD

17. Burial Date thereof June 25, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Episcopal Cem  
Location Mt. Savage, Md.

18. Funeral director J. P. Hanklin, M.D.  
Address 3 Easting, Md.

19. June 24, 1946 J. P. Hanklin, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 23, 1946 7:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
JUNE 17, 1946 to JUNE 23, 1946

and that I last saw her alive on JUNE 23, 1946

Immediate cause of death Cerebral Hemorrhage DURATION 7 days

Due to Hypertensive Cordia years  
Essential Blood Pressure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler, M.D. M. D. or other

Address 41 Lawrence Date signed June 23, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 5 1948  
BUREAU V.S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 266 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 12 W. SECOND ST.OR 304 CRAWFORD ST., CITY  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ARBOCAST, JOSEPH PATRICK

## 3. (b) Social Security Number

None

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

SINGLE

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

SEPTEMBER 13, 1945

## 8. AGE:

Years

Months

Days

If less than one day

723

hrs.

min.

## 9. Birthplace

Cumberland, Allegany Co., Md.  
(Town, county, and state)

## 10. Usual occupation

Child

## 11. Industry or business

## FATHER

## 12. Name

ARBOCAST, JOHN (DIVORCED)

## 13. Birthplace

Ridgely, West Virginia

## MOTHER

## 14. Maiden name

NIXON, GAY

## 15. Birthplace

MARYLAND, Cumberland

## 16. Informant

## Address

Gay Nixon Arbogast  
Cumberland Ind.

## 17.

(Burial, cremation, or removal, which?)

Date thereof

June 9, 1946  
(month) (day) (year)

## Cemetery or crematory

Oak Hill

## Location

Honaconing, Md.

## 18. Funeral director

Thomas Shinn, Jr.

## Address

Cumberland Ind.

## 19.

(Date rec'd by registrar)

June 8, 1946J. P. Franklin M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 6, 1946 at 6:05 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Sept 13, 1945 to June 6, 1946and that I last saw him alive on June 6, 1946

Immediate cause of death

SpontaneousConcurrent

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin M.D.  
Cumberland Ind.

Date signed

6/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

## CERTIFICATE OF DEATH

★ 05504  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Allegany  
City or town Westernport  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 83 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town 1 mi. East of Westernport  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Carolanne Biddle

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) 21 May 1863 8. (c) If alive, give age ..... years

8. AGE: Years 83 Months 0 Days 28 It less than one day ..... hrs. .... min.

9. Birthplace Baltimore-Baltimore-Maryland  
(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own home12. Name Charles Biddle13. Birthplace Baltimore, Md14. Maiden name Not known15. Birthplace not known16. Informant Mrs Calvin ArnoldAddress Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 22 June 1946  
(month) (day) (year)

Cemetery or crematory Philos CemeteryLocation Westernport, Maryland18. Funeral director Ellsworth S. BoalAddress 111 Church St., Westernport, Md19. June 22 1946 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 19 June 19 46, at 11 p. M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to June 19 1946  
and that I last saw h. er alive on June 18 1946

Immediate cause of death Congestive heart failure DURATION 3 day

Due to Hypertension 10 yrs.

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

13. SIGNATURE James S. Boal M. D. or otherAddress Richmont W. Va Date signed 6/21/46

RECEIVED  
JUN 24 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 125-2

05505

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

### 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
418 Columbia St.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 418 Columbia St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Charlotte Isabelle Billmyre

### 3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>William Billmyre</u>		
7. Birth date of deceased (mo., day, yr.) <u>Apr. 13, 1892</u>		
8. AGE: Years <u>54</u>	Months <u>2</u>	Days <u>6</u>
If less than one day .....hrs. ....min.		

9. Birthplace Austen, W. Va.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Jefferson Cozad

13. Birthplace W. Va.

14. Maiden name Lydia Helms

15. Birthplace W. Va.

16. Informant William Billmyre

Address 418 Columbia St. Cumberland, Md.

17. Burial Date thereof June 21, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HillCrest Burial Park

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. June 21, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1946 at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/15/46 19 to 6/19/46 19  
and that I last saw him alive on 6/19/46 19

Immediate cause of death

Toxic Hepatitis

Due to

Due to

Other conditions

Arthritis  
deformans  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Med. Bldg. Date signed 6/21/46



RECEIVED

JUN 25 1946

BUREAU VS



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B62)

## CERTIFICATE OF DEATH

05506

★ Reg. Dist. No. 9

### 1. PLACE OF DEATH:

County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 38 years  
Hospital, institution, or street address where death occurred:  
Miners Hospital  
How long in hospital or institution? 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Allegany  
City or town Zehlman, Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rural  
(If rural, give LOCATION)  
2.(a) If veteran, name war World War II ★

### 3. (a) FULL NAME

Eugene Blank

### 3. (b) Social Security Number

212-10-6332

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

### 8.(b) Name of husband or wife

8.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 13 - 1907

8. AGE: Years 38 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Zehlman, Allegany, Md.  
(Town, county, and state)

10. Usual occupation Laboer

11. Industry or business Brick Co.

12. Name Chas. E. Blank

13. Birthplace Wellsburg, Pa.

14. Maiden name Mrs. B. Stearns

15. Birthplace Zehlman, Md.

18. Informant Mrs. Benjamin Speyer

Address 82 Waplesburg St. Frostburg, Md.

17. Burial Date thereof 6-27-1946  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

19. Funeral director David Craper

Address Frostburg, Md.

19. 6-27 19 46 New Haven, N. H.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 46 at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 46 to June 24 19 46  
and that I last saw him alive on June 24 19 46

Immediate cause of death Cerebral Concussion DURATION 36 hrs

Due to Fall from stool

Due to Chronic alcoholism

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/23/46

Where did injury occur? Zehlman, Allegany, Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell from stool/stool and Injured at work?

23. SIGNATURE Hilda and Walter Speyer  
M. D. or other \_\_\_\_\_

Address Frostburg, Md. Date signed 6/25/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 28 1946  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

## CERTIFICATE OF DEATH

Reg. Dist. No. 05507 4

## 1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

7 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... ALLEGANYCity or town... CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)Street No... 610 MARYLAND AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

BOWARD, LESTER W. MR.

## 3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife... HINKLE, DAISY PEARL6. (c) If alive, give age 67 years

7. Birth date of

deceased (mo., day, yr.)

JUNE 12, 1882

8. AGE:

Years

Months

Days

If less than one day

631121

hrs.

min.

9. Birthplace

MARYLAND, Cumberland  
(Town, county, and state)

10. Usual occupation

WATCHMAKER @ W. L. BOWARD

11. Industry or business

ANTIQUES AND JEWELS

MOTHER

FATHER

12. Name

BOWARD, LEONARD R.

13. Birthplace

MARYLAND

14. Maiden name

MOCK, MATILDA

15. Birthplace

PA.

16. Informant

Mrs. William Boward

Address

610 Maryland Ave. Cumberland, Md

17.

BurialDate thereof June 6, 1946  
(month) (day) (year)

Cemetery or crematory

Peace Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

J. P. Frankel

Address

Cumberland, Md.

19.

June 6, 1946J. P. Frankel, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 3, 1946 at 7:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/15/46to 6/3/46and that I last saw him alive on 6/3/46

Immediate cause of death

Premia - Chronic interstitial nephritis, acute

Due to

Hypertension

Due to

Kidneys were sclerosed - kidney scler -osis. Duration 15 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland, Md Date signed 6/4/46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 11 1946  
BUREAU V.S.

Koon

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

05508

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 years  
 Hospital, institution, or street address where death occurred?  
113 Decatur  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 113 Decatur St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Susan G. Brooker

## 3. (b) Social Security Number

None

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Frank Brooker

## 7. Birth date of

deceased (mo., day, yr.)

February 24, 1884

## 8. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

It less than one day

82314

hrs.

min.

## 9. Birthplace

Near Springfield Hampshire Co. W. Va.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Own home

## FATHER

## 12. Name

James Blue

## 13. Birthplace

Romney W. Va

## MOTHER

## 14. Maiden name

Mary E. Umstot

## 15. Birthplace

Alaska, W. Va.

## 16. Informant

Carl H. Koerner

## Address

34 Weber St., Cumberland, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

June 10, 1946  
(month) (day) (year)

## Cemetery or crematory

Rose Hill Cemetery

## Location

Cumberland, Md.

## 18. Funeral director

John J. Hofer

## Address

Cumberland, Md.

## 19. June 10, 1946

(Date rec'd by registrar)

J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1946, at 80 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1946, to June 8, 1946and that I last saw him alive on June 8, 1946Immediate cause of death Chronic EndocarditisMyocardial Infarction

## DURATION

24 hrDue to Diabetes MellitusDue to Chronic Nephritis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Thos. A. KoernerAddress Cumberland, Md.

M. D. or other

Date signed 6/8/46

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

JUN 18 1946

BUREAU V S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

05509  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Allegheny  
City or town Oldtown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life time  
Hospital, institution, or street address where death occurred:  
Oldtown, Md  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Allegheny  
City or town Oldtown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

Newton M. Carder

### 3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Orpha Howell Carder  
6.(c) If alive, give age 41 years  
7. Birth date of deceased (mo., day, yr.) March 27, 1886  
8. AGE: Years 80 Months 3 Days 0 If less than one day  
.....hrs. ....min.

9. Birthplace Oldtown, Allegheny, Md.  
(Town, county, and state)  
10. Usual occupation Merchant  
11. Industry or business General store  
12. Name James Carder  
13. Birthplace Oldtown, Md.  
14. Maiden name Jane Twigg  
15. Birthplace Oldtown, Md

16. Informant Mrs. Bertha Wilkins  
Address Cumberland, Md  
17. Burial Date thereof June 30 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Hillcrest Cemetery  
Location Cumberland, Md

18. Funeral director John J. Hofer  
Address Cumberland, Md.

19. June 30, 46. Mrs C.A. Shmoltz  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1946 at 5:00 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to June 27 1946  
and that I last saw June 22 1946 alive on

Immediate cause of death Aspermin  
DURATION 2 wks  
Due to Chronic Myocarditis 2 yrs.  
Due to Arteriosclerotic Fibrosis 6 mos.  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Clayton J. Lurrell  
M. D. or other  
Address Cumberland Date signed June 29 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE AND STATEMENT ON HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUL 5 1946

BUREAU V.B.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05510

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 35 Years  
Hospital, institution, or street address where death occurred:  
532 North Centre St  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 532 North Centre St  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Peter George Charuhas

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife Grace M. Gregory Charuhas  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) February 2 1879  
8. AGE: Years 67 Months 4 Days 28 If less than one day hrs. min.

9. Birthplace Bordnia Sparto, Greece  
(Town, county, and state)  
10. Usual occupation Shoe Shop  
11. Industry or business Repairing Shoes  
12. Name George Charuhas  
13. Birthplace Bordonia Sparto, Greece  
14. Maiden name Stella Bali  
15. Birthplace Bordonia Sparto, Greece

16. Informant Christ G. Charuhas  
Address 532 North Centre St, Cumberland, Md.

17. Burial Date thereof 7/2/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Rose Hill Cemetery  
Location Cumberland, Md.

18. Funeral director William H. Kight  
Address Cumberland, Md.

19. July 2 19 46 J. P. Franklin M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH June 30 19 46, at 5 P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him dead June 30 19 46

Immediate cause of death Strangulation by hanging (suicide)  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Suicide Date of 6-30-46  
Where did injury occur? Cumberland Allegany Md.  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) at home  
Means of Injury Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or  
Address 125 Bedford St Date signed 6-30-1946  
Deputy Medical Examiner - Allegany Co

MARGIN RESERVED FOR BINDING

VS A15 9-45-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STANDARD INFORMATION SYSTEM

STANDARD INFORMATION SYSTEM

1. 12. 11

RECEIVED  
JUL 5 1946  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33a

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

05511

### 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 85 Years  
Hospital, institution, or street address where death occurred:  
Allegany County Infirmary  
How long in hospital or institution? 27. Months

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 131. Polk St  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Eleanor  
Emma Elmer Chisholm

### 3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widow</u>
8. (b) Name of husband or wife <u>Daniel Chisholm</u>		
8. (c) If alive, give age _____ years		
7. Birth date of deceased (mo., day, yr.) <u>August 9 1853</u>		
8. AGE: Years <u>92</u>	Months <u>10</u>	Days <u>6</u> It less than one day _____ hrs. _____ min.

9. Birthplace Grantsville, Garrett Co., Maryland  
(Town, county, and state)

10. Usual occupation House

11. Industry or business

MOTHER FATHER  
12. Name Jacob Brown  
13. Birthplace Grantsville, Md.  
14. Maiden name Eleanor Brumbaugh  
15. Birthplace Grantsville, Md.

16. Informant Mrs. B. W. O'Rourke  
Address 623. Bedford St, Cumberland, Md.

17. Burial Date thereof 6/18/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. June 18, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1946, at 8-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-17-46 to June 15, 1946 and that I last saw him alive on June 15, 1946

Immediate cause of death Cerebral Hemorrhage  
Generalized  
Arterio-sclerosis  
DURATION

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 9 months of death)  
Major findings of operations None Date of op. None

Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. F. Williams  
Address Cumberland Date signed 6-17-46

RECEIVED

JUN 25 1946

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

C5512

## CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH  
 County Allegany  
 City or town Corriganville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (If newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Corriganville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name War \_\_\_\_\_

3. (a) FULL NAME John. Edward Clauson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Clara M. Clauson  
 7. Birth date of deceased (mo., day, yr.) January 27, 1873 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 73 Months 4 Day 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ellerslie, Allegany, Maryland  
 (City, county, and state)

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name George A. Clauson

13. Birthplace Maryland

14. Maiden name La Anna Shaffer

15. Birthplace Maryland

16. Informant William C. Clauson

Address Corriganville, Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof June 17, 1946

Cemetery or crematorium Rose Hill

Location Cumberland, Md

18. Funeral director Harvey H. Feigler

Address Hyndman, Md.

19. June 15, 46 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 14 June 19 46 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to 14 June 1946  
 and that I last saw him alive on 14 June 1946 19 \_\_\_\_\_

Immediate cause of death Hypertension, diabetes with terminal cordens failure  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions hypertension, diabetes  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Alfred V. A. Dene  
 Address 110 S. Centre St. Cumberland, Md  
 Date signed 15 June 46

RECEIVED  
JUN 21 1946  
BUREAU V.S.

DR. E. E. B. OWENS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

★ 055134

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... ALLEGANY

City or town..... CUMBERLAND? MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital  
1 HOUR 55 MIN

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND County..... ALLEGANY

City or town..... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 152 WINEOW ST.?  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME Clara

BABY GIRL COLLINS

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE

COLORED

NEWBORN

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) JUNE 1, 1946

8. AGE: Years Months Days If less than one day  
1 hrs. 55 min.9. Birthplace Cumberland, Alleg. Co., Maryland  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name GLADYS COLLINS

15. Birthplace Norfolk, VIRGINIA

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Cremation Date thereof June 2, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MEMORIAL HOSPITAL

Location CUMBERLAND, MD.

18. Funeral director Same

Address

19. June 2, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1 1946 at 7:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1946 to June 1, 1946 and that I last saw him alive on June 1, 1946

Immediate cause of death

Premature birth

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 13325a Ave. Date signed 6/1/46

RECEIVED

JUN 11 1946

BUREAU V S



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

05514

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age. 71 years

8. AGE: Years Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereon

Cemetery or crematory

Location

18. Funeral director

Address

19. 6-26 46 Ms. Valley N. De

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... AlleganyCity or town..... Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 65 Park Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 25 19.. 46 at 7:40 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24 19.. 46 to June 25 19.. 46and that I last saw him alive on June 24 19.. 46

Immediate cause of death

acute cardiacdilatationDue to..... Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... W. O. McLaughlin M.D.Address..... Frostburg Md.Date signed..... 6-26-46

RECEIVED  
JUN 28 1946 .  
BUREAU V.B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164E)

## CERTIFICATE OF DEATH

Reg. Dist. No. 05515 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Potomac river within city

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 224 Emily St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

PEARL V. COMMER

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Joseph Commer

7. Birth date of deceased (mo., day, yr.) July 5, 1897  
 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 48 Months 11 Days 2 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bradshaw, W. Va.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joseph C. Foreback  
 13. Birthplace Penna.

14. Maiden name Anna Deneen  
 15. Birthplace Penna.

16. Informant Mr. Virgil EmerickAddress 224 Emily St. Cumberland, Md.

17. Burial June 10, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Hyndman Cem.Location Hyndman, Penna.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.

19. June 10, 1946 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1946 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1946 to June 7, 1946  
 and that I last saw him alive on June 7, 1946

Immediate cause of death

Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 6-7-46  
 Where did injury occur Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. P. Franklin, M.D.  
 M. D. or other

Address Cumberland Md. Date signed 6-7-46  
 Acting Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1946

BUREAU V.S.

2411 N. Charles St., Baltimore *MD*

DR. VANORMER

## CERTIFICATE OF DEATH

Reg. Dist. No. *4*

## 1. PLACE OF DEATH:

County *ALLEGANY*City or town *CUMBERLAND*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*MEMORIAL HOSPITAL*How long in hospital or institution? *42 DAYS*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MARYLAND* County *ALLEGANY*City or town *CUMBERLAND*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *456 N. CENTRE ST.*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*MRS. LILLIE G. CONNER*

## 3. (b) Social Security Number

*None*

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

WIDOWED

6. (b) Name of husband or wife *HARVEY CONNER*

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *OCT. 28 - 1871*8. AGE: Years Months Days If less than one day  
*74 7 22* hrs. min.9. Birthplace *MARYLAND*  
(Town, county, and state)10. Usual occupation *HOUSEWIFE*

11. Industry or business

12. Name *MICHAEL HINNELL*13. Birthplace *MARYLAND*14. Maiden name *MARY STERNER*15. Birthplace *MARYLAND*16. Informant *MEMORIAL HOSPITAL*Address *CUMBERLAND, MD.*17. *Addison Pa* Date thereof *June 22-46*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Cemetery*Location *Addison Pa*18. Funeral director *Hamberd Funeral Home*Address *Confluence Pa*19. *June 21, 1946* *J. P. Franklin, M.D.*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *JUNE 20* 19 *46* at *1:05 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1 May* 19 *46* to *20 June* 19 *46*  
and that I last saw him alive on *19 June* 19 *46*Immediate cause of death *Carcinoma of the Intestine*  
*trast with generalized*  
Due to *metastasis*

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results *not done*  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE *W. Alfred Van Orme*Address *1105 E. 21st Cumberland, Md.*  
Date signed *21 June 1946*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

So Center

RECEIVED  
JUN 25 1946  
BUREAU V 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05517

Reg. Diat. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

571 Patterson AveHow long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 871 Patterson Ave  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

Ann Elizabeth Cregan

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Patrick J. Cregan

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years 81 Months — Days 6 If less than one day — hrs. — min. —

9. Birthplace

Ireland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof

June 25 46  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. June 24, 1946  
(Date rec'd by registrar)J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 19 46 at 4:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/10/46 19 46 to 6/22 19 46and that I last saw him alive on 6/22/46 19 46

Immediate cause of death

myocarditis - chronic

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland Md Date signed 6/23/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 5 1946

BUREAU VS

53



Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

CERTIFICATE OF DEATH

05518

Reg. Dist. No.

4

1. PLACE OF DEATH:

County... Allegany  
City or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 Weeks  
Hospital, institution, or street address where death occurred:  
125 West 3rd St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... W. Va. County...  
City or town... Follensbee  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1036 Jefferson St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

David John Davies

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Bessie Keech Davies  
7. Birth date of deceased (mo., day, yr.) July 13, 1876  
8. AGE: Years 69 Months 10 Days 24 If less than one day hrs. min.

9. Birthplace Swansea, Wales (Town, county, and state)  
10. Usual occupation Retired (1932)  
11. Industry or business Tin Mill Worker  
12. Name William A. Davies  
13. Birthplace Swansea, Wales  
14. Maiden name Ann Thomas  
15. Birthplace Swansea, Wales

16. Informant Mr. Gomer Davies  
Address 125 W. 3rd St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 1946 (month) (day) (year)  
Cemetery or crematory Oak Grove Cem.  
Location Follansbee, W. Va.  
18. Funeral director Charles L. George  
Address Cumberland, Maryland.

19. June 11, 1946 J. P. Franklin, M.D. Registrar  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1946, at 8P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death Coronary Thrombosis (Death on Arrival)  
Due to...  
Due to...  
Other conditions...  
(Include pregnancy within 8 months of death)

Major findings of operations... Date of op...  
Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide... Date of...  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of Injury Injured at work?

23. SIGNATURE... M. D. or other  
Address... Date signed June 11, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 18 1946  
BUREAU V S.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

## CERTIFICATE OF DEATH

05519

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... Chesapeake  
 City or town... Chesapeake  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 27 days  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Pa County... Lancaster  
 City or town... Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Berlin, Pa. R.D. 3  
 (If rural, give LOCATION)  
 2(a) If veteran, name war... ☒

## 3. (a) FULL NAME

Robert A. Deeter

## 3. (b) Social Security Number

714-14-2854

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

M

## 6. (b) Name of husband or wife

Mrs. Hilda Deeter  
(Dresser) 38

## 7. Birth date of

deceased (mo., day, yr.)

Aug. 13, 1900

## 8. AGE:

Years

Months

Days

It less than one day

45928

hrs.

min.

## 9. Birthplace

Berlin, Pa.  
(Town, county, and state)

## 10. Usual occupation

Express Messenger

## 11. Industry or business

## FATHER

## 12. Name

Andrew Deeter

## 13. Birthplace

Pa

## MOTHER

## 14. Maiden name

Mary Smith

## 15. Birthplace

Pa.

## 16. Informant

Gertrude Johnson

## Address

Berlin, Pa.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

6-14-46  
(month) (day) (year)

## Cemetery or crematory

Berlin

## Location

Berlin, Pa.

## 18. Funeral director

W.A. Johnson

## Address

705 Main St., Berlin, Pa.

## 19.

June 12, 46  
(Date rec'd by registrar)

## 19.

J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 11, 1946

at

3:30 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1945 to June 11, 1946and that I last saw him alive on June 11, 1946

## Immediate cause of death

Generalized Peritonitis with Post-operative Adip

## Due to

Stress

## Due to

Leakage following Cholecystectomy

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Hepatitis, Pancreatitis

## Autopsy results

Peritonitis - Intest. Adip. etc.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

## Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

John H. Zupper, M.D.

M. D. or other

## Address

Harrisburg, Pa.Date signed 6-11-46

RECEIVED  
JUN 18 1945  
BUREAU V 8

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Unionland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 79 yrs 3 mo 16 da  
 Hospital, institution, or street address where death occurred:  
320 Fayette St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Unionland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 320 Fayette St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Theresa K. Dilger

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Chas. E. Dilger

7. Birth date of deceased (mo., day, yr.)

Mar. 10 1867

8. AGE: Years Months Days If less than one day

79 3 16 hrs. min.

9. Birthplace

Unionland Ind (Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

at Home

12. Name

Anthony Kienhofer

13. Birthplace

Germany

14. Maiden name

Katherine Schmidt

15. Birthplace

Germany

16. Informant

W Edwin Dilger

Address

Unionland

17. Burial (Burial, cremation, or removal, Which?) Date thereof

June 29 46 (month) (day) (year)

Cemetery or crematory

St Peter &amp; Pauls Con

Location

Unionland

18. Funeral director

Louis Stein Inc

Address

Unionland

19. Date rec'd by registrar

June 27, 1946

Registrar

J. P. Franklin, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1946 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1 1946 to June 26 1946

and that I last saw him alive on June 26 1946

Immediate cause of death

Coronary Thrombosis

DURATION 3 1/2 hours

Due to

Hypertensive Cardiovascular disease

Due to

None

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Blane M. Schneider M.D. or other

Address 41 Greenfield

Date signed June 18, 1946

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

*Prepared by*

ANTHONY J. L. G. B. R.

CONTENTS

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JUL 5 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5)

65521

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 52 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ann Marie Bonahue

## 3. (b) Social Security Number

214-01-3673

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Mar 4 - 1894

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

52229

hrs.

min.

9. Birthplace

Frostburg, Allegany, Md.  
(Town, county, and state)

10. Usual occupation

Office Clerk

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date used by registrar)

19.

46Wm. J. Price  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 166 BERRY  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 3

19.

46

at

5:30

PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 19 46 to June 3 46

and that I last saw him alive on

June 2 19 46

Immediate cause of death

Carcinoma of Breast

DURATION

15 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Wm. J. Price

M. D. or other

Address

Frostburg

Date signed

6-3-46



RECEIVED  
JUN 5 1946  
BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 984

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County... AlleganyCity or town... Frostburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleganyCity or town... Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 110 Center St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ella Dundon

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

John Dundon

## 7. Birth date of deceased (mo., day, yr.)

November 25, 1889

## 6. (c) If alive, give age

61 years

## 8. AGE:

Years 56 Months 6 Days 16  
If less than one day  
..... hrs. .... min.

## 9. Birthplace

Bihlman Allegany Cty., Md.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Home

## FATHER

12. Name... William Roney13. Birthplace... Maryland

## MOTHER

14. Maiden name... Sarah Hamilton15. Birthplace... Mt. Savage Md.16. Informant... John DundonAddress... Frostburg Md.17. Burial... Burial Date thereof... June 13, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... S. MichaelsLocation... Frostburg Md.18. Funeral director... J. R. DuerstAddress... Frostburg Md.19. 6-11 19. 46 Mrs. Nancy A. Roe  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 10 19. 46, at 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 13 19. 43 to June 10 19. 46and that I last saw him alive on June 10 19. 46

## Immediate cause of death

Ch. Myocarditis

## DURATION

2 mo

## Due to

Hypertension

## DURATION

several years

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

## Means of Injury

## Injured at work?

## 23. SIGNATURE

Wom Lane M. D. or other  
Address... Frostburg Md. Date signed... 6-11-46

RECEIVED

JUN 13 1946

BUREAU V S

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 187

05523

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Emmetsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 yrs  
 Hospital, institution, or street address where death occurred: Allegany Hospital  
 How long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For children, infants give residence of mother)  
 State Maryland County Allegany  
 City or town Emmetsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 544 Greene St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

James Thomas Emmart

## 3. (b) Social Security Number

214-07-0504

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Tipsa Flanagan  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 7 1898  
 8. AGE: Years 48 Months - Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Berkley Springs St. Va.  
 (Town, county, and state)  
 10. Usual occupation Fireman  
 11. Industry or business R.S. Fire Co.  
 12. Name John J. Emmart  
 13. Birthplace W. Va.  
 14. Maiden name Annie Morris  
 15. Birthplace Ind.

16. Informant Mrs. Jas O. Emmart  
 Address Emmetsburg  
 17. Burial Date thereof 6/25/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. P. & P. Cem.  
 Location Emmetsburg Ind.

18. Funeral director Donis Stein Inc  
 Address Emmetsburg  
 19. June 25, 1946 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6-21- 1946 at 8:45 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-14 to 6-21 and that I last saw him alive on 6-21

Immediate cause of death Broncho-Pneumonia DURATION 2 days  
 Due to Septicemia  
 Due to  
 Other conditions Broncho-Pneumonia  
Acute Bronchitis  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

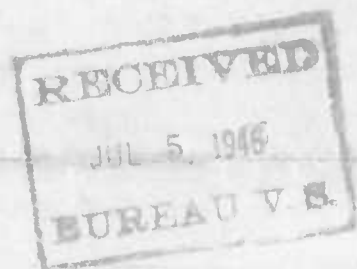
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Blaine M. Schneider M.D. M. D. or other  
 Address 41 Greenest Date signed June 22, 1946  
Emmetsburg Ind.

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Schindler

Outside of  
City Limits

7 E B Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

05524

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Allegheny  
City or town Near Cumberland, Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rt 2, Cumberland, Md, Baltimore Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny  
City Near Cumberland, Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 2, Baltimore Pike  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Leroy E. Frederick, Jr. - Twin 2

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

June 10, 1946

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

20

9. Birthplace

Rt 2, Cumberland Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

Leroy Earl Frederick

13. Birthplace

Topeka, Kansas

14. Maiden name

Ruth S. McCarty

15. Birthplace

Cumberland, Md

16. Informant

Leroy E. Frederick

Address

Rt 2, Cumberland, Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

June 12, 1946  
(month) (day) (year)

Cemetery or crematory

Hillcrest Cem

Location

Cumberland, Md.

18. Funeral director

John J. Hofer

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

June 12

1946

J. P. Stankin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 10

19 46

at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10

1946

to June 10

1946

and that I last saw him alive on

June 10

1946

Immediate cause of death

Premature birth

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W E B Owens MD

M. D. or other

Address

1330a ave

Date signed

6/10/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

Office of  
City Health

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 18 1945

BUREAU V



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

05525

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town near Cumberland, rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. 2, Baltimore Pike  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Virginia Lee Frederick - Turin 1st

## 3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) June 10, 1946

8. AGE:

Years

Months

Days

If less than one day

5 hrs. 15 min.9. Birthplace Rt. 2, Cumberland, Maryland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER  
MOTHER

12. Name

Leroy Earl Frederick

13. Birthplace

Topeka, Kansas

14. Maiden name

Iruth G. McCarty

15. Birthplace

Cumberland, Md

16. Informant

Leroy E. Frederick

Address

Rt. 2, Cumberland, Md

17.

(Burial, cremation, or removal, which?)

Date thereof

June 12, 1946  
(month) (day) (year)

Cemetery or crematory

Killebrew Cem

Location

Cumberland, Md

18. Funeral director

Address

Cumberland, Md

19.

(Date rec'd by registrar)

June 12, 1946J. P. Hanklin, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1946 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10, 1946 to June 10, 1946and that I last saw him alive on June 10, 1946

Immediate cause of death

Premature birth

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.E.B. Owens M.D.

M. D. or other

Address

1332 Va AveDate signed 6/10/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

JUN 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. TOLSON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 546

## CERTIFICATE OF DEATH

05526

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 YEARS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 9 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 766 FAYETTE STREET  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

WILLIAM L. GEPPERT

## 3. (b) Social Security Number

714-05-649

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITEMARRIED6. (b) Name of husband or wife RUTH HENKING6. (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) SEPT. 18, 18808. AGE: Years Months Days If less than one day  
63 9 2 .....hrs. ....min.9. Birthplace OHIO  
(Town, county, and state)10. Usual occupation NEWSPAPER EDITOR

11. Industry or business

12. Name WILLIAM GEPPERT13. Birthplace OHIO14. Maiden name SIMONETTA KILLMARTIN15. Birthplace OHIO16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof June 23 '46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland18. Funeral director Louis Stein, Inc.Address Cumberland19. 6-22 19 46 Joe P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 20, 19 46 at 4:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-11- 19 46, to 6-20- 19 46and that I last saw him alive on 6-20- 19 46Immediate cause of death Carcinoma prostate  
Duration about 2 yrs.

Due to

Due to

Other conditions arteriosclerosis  
chronic nephritis  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson, M.D.  
M. D. or otherAddress Cumberland, Md. Date signed 6-20-46

RECEIVED  
JUN 25 1946  
BUREAU V S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

## CERTIFICATE OF DEATH

★ 05527 4  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

217 Glenn St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County HarrisonCity or town Clarksburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. Washington Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Anna B. Gibson

## 3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Thomas W. Gibson

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

January 15, 1859

8. AGE:

Years

87

Months

4

Days

22

If less than one day

\_\_\_\_\_ hrs.

\_\_\_\_\_ min.

9. Birthplace Piedmont, Mineral, W. Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name

David Scott

13. Birthplace

Scotland

MOTHER

14. Maiden name

Jean Kelso

15. Birthplace

Scotland16. Informant Anna B. McVeighAddress 217 Glenn St., Cumberland17. Burial  
(Burial, cremation, or removal. Which?)Date thereof June 10, 1946  
(month) (day) (year)Cemetery or crematory Old Coney CemeteryLocation Near Lanaxening, Md.

18. Funeral director

Address J. P. Franklin, 24d.19. June 10, 1946  
Date rec'd by registrarJ. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1946, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8, 1946 to June 7, 1946  
and that I last saw h. live on June 8, 1946

Immediate cause of death

Carcinoma of face - ear  
right side

DURATION

about  
7 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. V. Downing M. D. or otherAddress 125 B. 8th St. Date signed 6-8/46Acting Deputy Medical Examiner

MARGIN RESERVED FOR BINDING

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 18 1946  
BUREAU V.S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:  
County... ALLEGANY  
City or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? TWO DAYS  
Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
How long in hospital or institution? TWO DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... PENNSYLVANIA County... BEDFORD  
City or town... BEDFORD  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION) ☒  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
GILCHRIST, MAUD MRS.  
3. (b) Social Security Number  
None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED  
6.(b) Name of husband or wife GILCHRIST, SAMUEL MR.  
6.(c) If alive, give age 67 years  
7. Birth date of deceased (mo., day, yr.) AUGUST 10, 1886  
8. AGE: Years 59 Months 10 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace WEST VIRGINIA  
(Town, county, and state)  
10. Usual occupation HOUSEWIFE  
11. Industry or business \_\_\_\_\_  
12. Name MCKEE, THOMAS  
13. Birthplace VIRGINIA  
14. Maiden name FOREMAN, ELLA MRS.  
15. Birthplace VIRGINIA

16. Informant MEMORIAL HOSPITAL  
Address CUMBERLAND, MD.

17. Burial Date thereof June 27 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Bedford  
Location Bedford, Pa  
18. Funeral director Atton J. Barefoot  
Address Bedford, Penna.  
June 25, 46 J.P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH JUNE 24 19 46, at 7:55 P. M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 to June 24, 46  
and that I last saw him alive on June 24, 1946  
Immediate cause of death Coronary Thrombosis DURATION 7 days  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings of operations None Date of op. None  
Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE W.F. Williams M.D. Other \_\_\_\_\_  
Address Cumberland Date signed 6-25-46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JUL 5 1946  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

055294

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County MineralCity or town Keyser W. Va.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 23 Spring St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Joshua Benton Gillum

## 3. (b) Social Security Number

705-09-7458

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

maleWhiteWidowedB. (b) Name of husband or wife Anna K. Gillum

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 18718. AGE: Years Months Days If less than one day  
75 2 24 hrs. min.9. Birthplace Bedford Valley, Bedford Co., Penna.  
(Town, county, and state)10. Usual occupation Retired - Car Foreman11. Industry or business R. R. Co. (B. & O.)12. Name John Gillum13. Birthplace Bedford County, Penna.14. Maiden name Victoria Brunner15. Birthplace Bedford County, Penna.16. Informant Mrs. Marshall T. VirtsAddress Keyser, W. Va.17. Burial Date thereof June 11, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Queen's Rest CemLocation Keyser, W. Va.18. Funeral director J. H. Markwood SonsAddress Keyser, W. Va.19. June 10, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 46 5 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on June 6-8 19 46Immediate cause of death  
Coronary occlusionDURATION  
immediate  
ly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or other

Address Date signed

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9.45-1.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

## 1. PLACE OF DEATH:

County AlleganyCity or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Margaret Cecelia Grahame

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

8. (b) Name of husband or wife

John C. Grahame

7. Birth date of deceased (mo., day, yr.)

October 8, 1875

5. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

70724

hrs.

min.

9. Birthplace

Mt. Savage, Allegany, Md.  
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

home

FATHER

12. Name

George H. Malloy

13. Birthplace

New York

MOTHER

14. Maiden name

Mary Elizabeth Dull

15. Birthplace

Perry, Indiana

16. Informant

George Grahame

Address

Mt. Savage, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

June 5, 1946  
(month) (day) (year)

Cemetery or crematory

St. Patrick's

Location

Mt. Savage

18. Funeral director

J. R. Durst

Address

Frederick, Md.

19.

(Date rec'd by registrar)

June 4, 46James M. V. Smith  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 219 46, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan19 45, toJune 219 46

and that I last saw him alive on

May 1519 46

Immediate cause of death

Coronary Arteriosclerosis

DURATION

5 months

Due to

Hypertension, heart disease2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. G. Munn

M. D. or other

Address

Cumtubund, Md.Date signed June 4/46

RECEIVED

JUL 23 1946

BUREAU V. R.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

05531

Reg. Dist. No. 4

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 dayHospital, institution, or street address where death occurred:  
MEMORIAL HOSPITALHow long in hospital or institution? 1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANYCity or town... New Cumberland Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Mexico Farms, R.R. #4  
(If rural, give LOCATION)

2.(d) If veteran, name war

## 3. (a) FULL NAME

BABY BOY GRAPES

## 3. (b) Social Security Number

None4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced  
Single  
INFANT (PREMATURE)

8.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7, 19468. AGE: Years 0 Months 0 Days 1 If less than one day  
hrs. min.9. Birthplace... CUMBERLAND, MD.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William Reuschel13. Birthplace Cumberland, Md.14. Maiden name HELEN GRAPES15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof June 10, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetary or crematory Brothman CemeteryLocation Flintstone, Md.18. Funeral director John J. HoffAddress Cuffebridge, Md.19. June 10, 1946 J. P. Franklin, M.D.  
Date rec'd by registrar Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 8 19 46 at 11:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 7, 1946 to 8, 1946and that I last saw him alive on 19Immediate cause of death Premature DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Clayton L. Lerner M. D. or otherAddress Cumberland Date signed June 9, 1946

MARGIN RESERVED FOR BINDING

VS A15 9.45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1946

BUREAU V S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

05532

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hosp.  
 How long in hospital or institution? 6 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Alleg.  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 310 Harrison  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lydia Groff

## 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Adrius Groff

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan. 15 1857

8. AGE: Years 89 Months 4 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pa., Somerset County  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Solomon Engle13. Birthplace Pa.14. Maiden name Dinah Kime Engle15. Birthplace Pa.16. Informant M. Dawson R.N.Address Cumberland, Md.

17. Burial Cem. Date thereof June 6 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory I.O.O.F. CemLocation Berlin, Pa.18. Funeral director W.A. JohnsonAddress Berlin, Pa.

19. June 3 19 46 Joe P. Frankis, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3/46 19\_\_\_\_ at 745 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/25/46 19\_\_\_\_ to 6/3/46 19\_\_\_\_  
 and that I last saw her alive on 6/2/46 19\_\_\_\_

Immediate cause of death Myocardial Failure

DURATION

Due to Chronic Myocarditis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. Williams, M.D.Address Medical Bldg Date signed 6/3/46

Cumberland, Md.

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 11 1946  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05533 4

## 1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 50 MINUTES

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANYCity or town... PUNACONTING, MD.  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Alexander Groves

## 3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

FEB. 16, 1946

8. AGE:

Years

Months

Days

If less than one day

323

hrs.

min.

9. Birthplace... PUNACONTING, MD.

(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER

12. Name

ALEXANDER GROVES

13. Birthplace

MD.

MOTHER

14. Maiden name

EVA BEEMAN

15. Birthplace

MD.

16. Informant

Address

Memorial Hospital  
Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof June 11, 1946  
(month) (day) (year)

Cemetery or crematory

Methodist Cem

Location

Mt. Savage Md.

18. Funeral director

Address

M. E. Eickman  
Lonaconing, Md.

19.

(Date rec'd by registrar)

19 46J.P. Hanklin, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 9... 19 46... at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 21st 19 46, to June 9 19 46and that I last saw him alive on June 9 19 46

Immediate cause of death

DURATION

Myocardial InfarctionDue to Myocardial InfarctionDue to Myocardial InfarctionOther conditions 7 1/2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work? .....

23. SIGNATURE.....

M. D. or other

Address... Cumberland Md. Date signed 6-9-46

RECEIVED

JUN 18 1946

BUREAU V S

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 yrs  
Hospital, institution, or street address where death occurred:  
607 Virginia Ave  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 607 Virginia Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Charles Elizabeth Hardesty

3. (b) Social Security Number

705-09-3721

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Marie Boswell

7. Birth date of deceased (mo., day, yr.) Dec 3 1890 6. (c) If alive, give age years

8. AGE: Years 55 Months 6 Days 3 If less than one day hrs. min.

9. Birthplace Terra Alta W. Va.  
(Town, county, and state)

10. Usual occupation yard foreman B & O Ry

11. Industry or business Retired 4 yrs

12. Name Bushrod Hardesty

13. Birthplace W. Va.

14. Maiden name Mary E. Eversley

15. Birthplace W. Va.

16. Informant Marie Boswell Hardesty

Address 607 Virginia Ave

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 8, 1946  
(month) (day) (year)

Cemetery or crematory Terra Alta W. Va.

Location Terra Alta W. Va.

18. Funeral director Louis Stein Inc

Address Cumberland, Md.

19. June 8, 1946 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 46 at 1:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1946 to June 6, 1946

and that I last saw him alive on June 6, 1946

Immediate cause of death bronchial asthma

Other conditions

Due to Myocarditis

Due to Chronic

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton J. Surges M. D. or other

Address Cumberland Date signed June 7, 1946

MARGIN RESERVED FOR BINDING

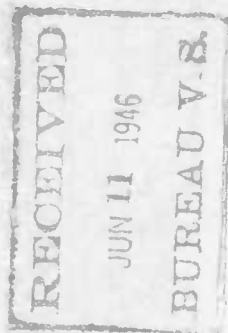
VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Please  
Sign  
these  
and place on  
the mantle

---

C.H.S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05535 4  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 14 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANYCity or town... LUKE, MD.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

HARVEY, CLARA A. MRS.

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALEWHITEMARRIED6. (b) Name of husband or wife... HARVEY, VICTOR H.6. (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.)

Feb. 12, 1900

8. AGE:

Years

Months

Days

If less than one day

46321

hrs.

min.

9. Birthplace... MARYLAND

(Town, county, and state)

10. Usual occupation... HOUSE

11. Industry or business

12. Name... BELL, HARRY13. Birthplace... PA.14. Maiden name... MASON, ALICE15. Birthplace... MARYLAND

16. Informant

Address

17. Buried

(Burial, cremation, or removal. Which?)

Date thereof June 5, 1946  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. June 5, 1946

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 3, 1946 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20, 1946, to 6:30, 1946and that I last saw him alive on June 3, 1946

Immediate cause of death

DURATION

Metastases to brain from carcinoma of rt. breast

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

of rt. breast Date of op. June 3, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

W. F. Williams M. D. or otherAddress Cumberland Date signed 6-4-46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

RECEIVED

RECEIVED  
JUN 11 1946  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

05536

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumbersland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred  
1906 Bedford St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumbersland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1907 Bedford St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Judith Ann Hast.  
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

None

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 28 1944  
 8. AGE: Years 2 Months 4 Days 27 If less than one day  
hrs. min.

9. Birthplace Cumbersland Ind.  
 (Town, county, and state)  
 10. Usual occupation none

11. Industry or business  
 12. Name Lewis Frederick Hast  
 13. Birthplace Cumbersland Ind

14. Maiden name Dorothy Eleanor Wilson  
 15. Birthplace Cumbersland Ind

16. Informant Lewis F. Hast  
 Address Cumbersland

17. Burial, cremation, or removal. When? 6/27/46  
 (month) (day) (year)

Cemetery or crematory St Lukes Cem.  
 Location Cumbersland Ind

18. Funeral director Louis Stein Inc.  
 Address Cumbersland

19. June 27, 1946 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him ER June 25 1946

Immediate cause of death Drowning

Due to fell in fish pond

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-25-1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Downing M.D. M. D. or other

Address June 27, 1946 Date signed 6/25/46

Acting Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A157 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 5 1946  
BUREAU VS

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B72)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

11 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PA County Franklin  
 City or town RT. #3, MERCERSBURG, PA.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOHN S. HAYS

## 3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

BERTHA HOPT HAYS8.(c) If alive, give age 68 years

7. Birth date of

deceased (mo., day, yr.) JAN. 21 1876

8. AGE:

Years

70

Months

5

Days

9

If less than one day

hrs.

min.

9. Birthplace

PENNA.

(Town, county, and state)

10. Usual occupation

Laborer - Retired

11. Industry or business

FATHER

12. Name

EDWARD HAYS

13. Birthplace

PA.

MOTHER

14. Maiden name

BERTHA STEFFEY

15. Birthplace

PA

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

July 3 46  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46

J.P. Franklin, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 30 1946 at 6:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-19- 1946, to 6-30- 1946  
 and that I last saw him alive on 6-29- 1946

Immediate cause of death

Benign hypertrophy of prostate

DURATION

7

Due to

Due to

Other conditions

Chronic nephritis  
arteriosclerosis  
(Include pregnancy within a month of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

7-1-46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 5 1946  
BUREAU V.S.

WAS CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 178-0

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

05538

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one hour

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? one hour

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)Street No. Calla Hill  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Leona Himmelwright

## 3. (b) Social Security Number

712-14-1512

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Raymond H. Himmelwright6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) August 31, 18988. AGE: Years Months Days If less than one day  
47 9 16 ..... hrs. .... min.9. Birthplace Md.  
(Town, county, and state)10. Usual occupation housewife & C&P R.Ry. Office11. Industry or business R.Ry.12. Name Samuel Barncord13. Birthplace Md.14. Maiden name Minnie Bogh15. Birthplace Pa.16. Informant Anna Higgins (sister)Address Mt. Savage Md.17. Burial Date thereof June 19, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Georges CemeteryLocation Mt. Savage Md.18. Funeral director J. J. DurstAddress Frostburg Md.19. 6-17 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1946 at 12.30 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-16 1946 to 6-16 1946 and that I last saw her dead 6-16 1946

Immediate cause of death

Fractured Skull about 1-1/2 hrs

DURATION

Due to Automobile accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-15-46Where did injury occur? Mt. Savage, Allegany, Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Automobile accident Cause of work? No23. SIGNATURE H. V. Deming, M.D. H. V. Deming, M.D.  
M. D. or otherAddress 125 Bedford St. Cumberland Date signed 6-16-46Deputy Medical Examiner - Allegany Co.

RECEIVED

JUN 25 1946

BUREAU V. 8



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 05539 4  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 317 Magnolia St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

~~Elizabeth~~ Hinea, Baby Girl

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 1 1946

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
4 hr. 10 min.9. Birthplace Cumberland Ind.  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Chas T Hinea13. Birthplace Pluma.14. Maiden name Rancy Moore15. Birthplace N. Va.16. Informant Chas T HineaAddress Cumberland17. Burial Date thereof June 3 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Peter & Pauls CemLocation Cumberland18. Funeral director Louis Stein IncAddress Cumberland19. June 3 46 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1946 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 31 1946 to June 1 1946and that I last saw him alive on June 1 1946Immediate cause of death premature baby (5 months)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. Hines MD M. D. or otherAddress Long Mar Date signed 6-1-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 - 1946

BUREAU VS

Outside of  
City Limits

Paulman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82-2

CERTIFICATE OF DEATH

05540

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny  
City Near Cumberland, Federal  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years  
Hospital, institution, or street address where death occurred:  
Rt 3, Rousman's Addition  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegheny  
City Near Cumberland, Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 3, Rousman's Addition  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Isaac M. Hook

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Georgia Hymas Hook  
6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Oct 13, 1873

8. AGE: Years 72 Months 7 Days 22 If less than one day  
.....hrs. ....min.

9. Birthplace Artemas, Pa.  
(Town, county, and state)

10. Usual occupation Laterer

11. Industry or business General

MOTHER FATHER 12. Name Isaac Hook

13. Birthplace Pennsylvania

14. Maiden name Unknown

15. Birthplace

18. Informant Lawrence Hook

Address Rt. 3, Cumberland, Md

17. Burial Date thereof June 8, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairview Christian Cemetery

Location near Artemas, Pa.

18. Funeral director John J. Hoyer

Address Cumberland, Md.

19. June 8, 1946 J. P. Franklin M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1946 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 5, 1946 to June 5, 1946  
and that I last saw him alive on June 5, 1946

Immediate cause of death Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. P. Paulman  
M. D. or other

Address Low Bldg. Date signed 6/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1945

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (459)

05541

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. GRACIE

## 1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... WEST VIRGINIA County... MINERAL

City or town... KEYSER  
(If outside city or town limits, write RURAL and give nearest town)Street No... 30 MINERAL ST.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MR. GEORGE R. HOUSEHOLDER

## 3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

LAURA KEYSER

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

NOVEMBER 19, 1891

8. AGE:

Years

Months

Days

It less than one day

74

7

7

hrs.

min.

9. Birthplace

MARYLAND, Westport, Allegany Co.  
(Town, county, and state)

10. Usual occupation

RETIRED Carman

11. Industry or business

B. and O. R. R. Co.

FATHER

12. Name

WILLIAM R. HOUSEHOLDER

MOTHER

13. Birthplace

WEST VIRGINIA, Hampshire Co.

14. Maiden name

HANNA HARRISON

15. Birthplace

WEST VIRGINIA, Hampshire Co.

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, ID.

17. Burial

(Burial, cremation, or removal. Which?)

Date there... June 29, 1946  
(month) (day) (year)

Cemetery or crematory

Greenspoint Cem

Location

Keiser, W. Va.

18. Funeral director

N. L. Rogers

Address

Keiser, W. Va.

19. June 28, 1946.

(Date rec'd by registrar)

J. P. Franklia, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 26, 1946 3:02 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 25, 1946, to JUNE 26, 1946

and that I last saw him alive on JUNE 26, 1946

Immediate cause of death

Cerebral aneurysm

DURATION

Due to

Cerebral aneurysm of right

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. Gracie

M. D. or other

Address... Keiser, W. Va. Date signed... June 28, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1946

BUREAU V S.

DR. S. HAWKINS & W. F. WILLIAMS MARYLAND STATE DEPARTMENT OF HEALTH  
WILLIAMS 2411 N. Charles St., Baltimore (462)  
CERTIFICATE OF DEATH

05542

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND  
(If outside corporate limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL 6 weeks

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town FROSTBURG  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 70 E. LOO STREET

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

MRS. EMMA JANE HUNTER

## 3. (b) Social Security Number

none

4. Sex FEMALE	5. Color or race WHITE	6. (a) Single, married, widowed, or divorced WIDOWED
------------------	---------------------------	---

8. (b) Name of husband or wife SAMUEL J. HUNTER

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 5, 1868

8. AGE: Years 78	Months 3	Days 13	It less than one day hrs. min.
---------------------	-------------	------------	-----------------------------------

9. Birthplace PENNA. (Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business

12. Name JOSEPH HUNSICKER

13. Birthplace PENNA.

14. Maiden name ESTHER HARTUNG

15. Birthplace PENNA.

16. Informant J. S. HUNTER

Address FROSTBURG, MD.

17. Burial Date thereof June 20, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Charles Evans Cemetery.

Location Reading, Penna.

18. Funeral director J. J. Durst.

Address Frostburg, Md.

19. June 18, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2:10 A.M.

20. DATE OF DEATH JUNE 18, 1946 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 1946 to June 17, 1946

and that I last saw her on June 17, 1946

Immediate cause of death P.O. Byerson  
With Starvation DURATION

Due to

Evulsion Pectoral Artery  
Cobain for Cancer

Other condition Suppurative

1820 - 1820 - 1820  
(Include pregnancy within 3 months of death)

Major findings Psychosis

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins

M. D. or other

Address Cecil Md. Date signed 6-18



RECEIVED  
JUN 25 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County... AlleganyCity or town... Frostburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

42 W. Loo St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State... Maryland County... AlleganyCity or town... Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No... 42 W. Loo  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

William Conner Hunter

## 3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Henrietta Hunter

7. Birth date of

deceased (mo., day, yr.)

October 26, 1865

6. (c) If alive, give age... years

8. AGE:

Years

80

Months

7

Days

4

If less than one day

...hrs. ...min.

9. Birthplace

Washington D. C.  
(Town, county, and state)

10. Usual occupation

retired sub-station operator

11. Industry or business

Potomac Edison Co.

FATHER

12. Name... William Hunter

13. Birthplace

Washington D. C.

MOTHER

14. Maiden name... Elizabeth Conner

15. Birthplace

Maryland

16. Informant

Mrs. Elizabeth Williams

Address

Frostburg, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Johnson Cemetery

Location

Harrett County

18. Funeral director

Address

J. R. Overst  
Frostburg, Md.

19. (Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 1... 19... 46... at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

sudden death... 19... 19...

and that I last saw him... alive on... 19...

Immediate cause of death

Coronary Arteriosclerosis

DURATION

sudden

Due to

Hypertension

Due to

several years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm C Lane Jr  
Frostburg, Md.

M. D. or other

Address

Date signed... 6-3-46

RECEIVED

JUN 5 1946

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

05544

Reg. Dist. No.

4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 hours 50 minutes

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 10 hours 50 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County MineralCity or town Ridgeley  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Baby Boy Jewell

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.) June 9, 1946

## 8. AGE:

Years

Months

Days

If less than one day

10 hrs.50 min.9. Birthplace Cumberland, Maryland

(Town, county, and state)

10. Usual occupation New born premature infant

## 11. Industry or business \_\_\_\_\_

FATHER

12. Name Paul M. Jewell13. Birthplace West Virginia

MOTHER

14. Maiden name Maydelle Stafford15. Birthplace West Virginia16. Informant Memorial HospitalAddress Cumberland, Maryland17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof June 10, 1946  
(month) (day) (year)Burial or crematory MEMORIAL HOSPITALLocation Cumberland Md.18. Funeral director Same as above

Address \_\_\_\_\_

19. June 10, 1946 J. P. Frankie, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 June 1946, to 9 June 1946  
and that I last saw him alive on 9 June 46

Immediate cause of death

congenital atelectasis  
Prematurity

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_

23. SIGNATURE Guller B Whitworth

M. D. or other

Address 112 Bedford St Date signed 10 June

MARGIN RESERVED FOR BINDING

VS-A15 9-45-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1946

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity Box 7, Route 1, Locust Grove  
(If outside city or town limits, write RURAL and give nearest town)Street No. Box 7, Route 1, Locust Grove  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Johnson, Bertha Mrs.

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Daniel E.6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) June 18, 18858. AGE: Years 60 Months 11 Days 17 If less than one day

hrs. min.

9. Birthplace Pa. McKeesport  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Richard D. Avery13. Birthplace England14. Maiden name Ellen Dalrymple15. Birthplace France16. Informant Dorothy PhillipsAddress 3711 Macomb St. N.W. Washington, D.C.17. Burial Date thereof June 8, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Zion Memorial ParkLocation Cumberland, Md.18. Funeral director John J. HoffAddress Cumberland, Md.19. June 8, 1946 Registrar J. Franklin, M.D.  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5/46 19 46 at 12:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4, 1946 to June 5, 1946and that I last saw him alive on June 5, 1946Immediate cause of death apoplectic insultDURATION 2 daysDue to arteriosclerosisDue to renalOther conditions yes

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Moans of injury Injured at work?

23. SIGNATURE L. Phillips M.D.  
M. D. or otherAddress Long Mt Date signed 6-6-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED

JUN 11 1946

BUREAU V.S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

★ 05546

Reg. Diat. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:  
Frederick St., extended

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. Frederick St., extended  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth K. Jones

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteMarried6. (b) Name of husband or wife John Jones

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 16, 18868. AGE: Years Months Days If less than one day  
59 11 16 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Cumberland, Allegany, Maryland  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Chas. Hofer13. Birthplace Germany14. Maiden name Unknown15. Birthplace "16. Informant John JonesAddress Frederick St. Cumberland, Md17. Burial Date thereof June 6, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sumner CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Maryland19. June 5 19 46 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd a.m. 1946 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION

Coronary Occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cardio-renal-vascular  
disease 1 yr.  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE William H. Kight, M.D.  
M. D. or otherAddress Cumberland, Maryland Date signed 6-3-46Deputy Medical Examiner Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9.45.75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE BUREAU OF THE ARMY

RECEIVED BY THE BUREAU OF THE ARMY

RECEIVED

JUN 11 1946

BUREAU VS

## CERTIFICATE OF DEATH

★ 05547

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 HOURS & 15 MINS.

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 5 HOURS & 15 MINS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETTCity or town ACCIDENT  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(b) Social Security Number

None

## 3. (a) FULL NAME

LAVERTA MAE KAHL4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) JUNE 16, 19468. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 5 hrs. 15 min.9. Birthplace ACCIDENT, MARYLAND  
(Town, county, and state)10. Usual occupation NEW BORN

11. Industry or business \_\_\_\_\_

12. Name RAYMOND KAHL13. Birthplace MARYLAND14. Maiden name NELLIE DETRICK15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MARYLAND17. Burial Date thereof June 17, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory German Lutheran Cem.Location Accident, Md.18. Funeral director Wm. WinterbergAddress Shantville, Ind.19. June 17, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 16 19 46 at 3:05 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 19 46 to June 16 19 46 and that I last saw him alive on June 16 19 46

Immediate cause of death \_\_\_\_\_

DURATION

Due to Prematurity

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_

23. SIGNATURE C. L. Owens, M.D.

M. D. or other

Address Cumberland, Md. Date signed 6-16-46

MARGIN RESERVED FOR BINDING

VS A15

9.45.13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 25 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

★05548

Reg. Dist. No. 9

### 1. PLACE OF DEATH:

County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 67 W. 2nd St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

Francis Patrick Kelly

### 3. (b) Social Security Number

217-10-6069

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

B.(b) Name of husband or wife Margaret Deane

7. Birth date of deceased (mo., day, yr.) June 16-1896 8.(c) If alive, give age 49 years

8. AGE: Years 50 Months 0 Days 5 If less than one day

9. Birthplace Eckhart, Allegany, Md  
(Town, county, and state)

10. Usual occupation machinist

11. Industry or business Wendell Paper Co

12. Name Francis P. Kelly

13. Birthplace Eckhart, Md

14. Maiden name Christina Eckhart

15. Birthplace Eckhart, Md

16. Informant John P. Kelly

Address 67 W. 2nd St. Frostburg

17. Burial Date thereof 6-24-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michael's Cemetery

Location Frostburg, Md

18. Funeral director Garrett Walker

Address Frostburg, Md

19. 6-24 1946 (Date rec'd by registrar)

Register

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1946 to June 20 1946.

and that I last saw him alive on June 20 1946.

Immediate cause of death Coronary Occlusion

DURATION 1 hour

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. G. Gattens MD

Address Frostburg, Md Date signed 6/21/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 26 1946  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

## CERTIFICATE OF DEATH

05549  
Reg. Dist. No. 9

### 1. PLACE OF DEATH:

County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Lifetime  
Hospital, institution, or street address where death occurred:  
Miners Hospital  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. B.F.D. #1  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Ann O'Neal Kenney

### 3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife John Joseph Kenney

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1876

8. AGE: Years 69 Months 9 Days 21 If less than one day — hrs. — min.

9. Birthplace BARTON ALLEGANY CO., MD.  
(Town/county, and state)

10. Usual occupation

11. Industry or business

12. Name John O'Neal

13. Birthplace Ireland

14. Maiden name Sarah McManus

15. Birthplace Ireland

16. Informant Mary B. Kenney

Address 1618 Palworth Rd., Balto., Md.

17. Funeral Date thereof June 5th 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg Md

18. Funeral director Jacob Haper

Address Frostburg, Maryland

19. 68 46 Wm. J. M. Price  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1946 at 330 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1946 to June 5 1946 and that I last saw her alive on June 3 1946

Immediate cause of death Chronic myocarditis DURATION several  
no

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm Lane M. D. or other

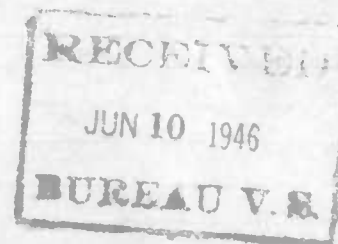
Address Frostburg Md Date signed 6-7-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

## CERTIFICATE OF DEATH

05550

Reg. Dist. No. 1

## 1. PLACE OF DEATH:

County AlleganyCity or town Keifer  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 yrs.Hospital, institution, or street address where death occurred:  
Rt. #1 Paw Paw H. Va.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Keifer  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. 1 Paw Paw H. Va.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Hilda Virginia

## 3. (b) Social Security Number

None4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Edmore Kerns7. Birth date of deceased (mo., day, yr.) July 9 18638. AGE: Years 87 Months 11 Days 17 If less than one day8. (c) If alive, give age — years9. Birthplace Flintstone Ind  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Jacob Keifer13. Birthplace Ind.14. Maiden name Unknown

15. Birthplace

16. Informant Almyr KernsAddress Keifer Ind.17. Burial Date thereof 6-28-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Green Ridge Cem.Location Green Ridge Ind18. Funeral director Louis Stein IncAddress Crumbsland19. 6/28 19 46 Mrs E.A. Shonholtz  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 46 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 6-24 19 46and that I last saw h. ex alive on 6-24-46 19 46Immediate cause of death Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Easton M.D. M. D. or otherAddress Cherry St. Date signed 6-27-46

RECEIVED

JUL 5 1946

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

05551

4

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

215 Beall St

How long in hospital or institution?

## 3. (a) FULL NAME

Alice May Kidwell

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife John J. Kidwell7. Birth date of deceased (mo., day, yr.) June 29 1879 8. (c) If alive, give age - years8. AGE: Years 67 Months - Days 2 If less than one day9. Birthplace Scotdale Pa.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Jacob W. Fortney13. Birthplace Kingwood W. Va.14. Maiden name Estellinda Stuck15. Birthplace Kingwood W. Va.16. Informant Mrs. Alice WardAddress Cumberland17. Burial Date thereof July 1 46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland18. Funeral director John Stein Inc.Address Cumberland19. July 1 46 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 215 Beall St  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1946 at 11:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3 61 1945 to 6 27 1946and that I last saw him alive on 6-27-46

Immediate cause of death

DURATION

Carcinoma of rt. breast

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. F. Williams

M. D. or other

Address Cumberland Date signed 6-28-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Williams

JUL 3 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05552

DR. ENFIELD

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town... ACCIDENT  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

KING, DAVID A. MR.

4. Sex

MALE

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife... MRS. OLIVE KING

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) AUGUST 19, 1866.

8. AGE: Years Months Days If less than one day

79

9

25

hrs. min.

9. Birthplace... MARYLAND  
(Town, county, and state)

10. Usual occupation... RETIRED

11. Industry or business

12. Name KING, EDWARD E.

13. Birthplace GERMANY

14. Maiden name FREELAND, MARY

15. Birthplace WEST VIRGINIA

16. Informant Mrs. King

Address Evans City Pa

17. Burial, cremation, or removal... Date thereof 6-17-1946  
(month) (day) (year)

Cemetery or crematory Breton Cem

Location Accident, Md.

18. Funeral director Mrs. McIntosh

Address Grantville Md

19. June 17, 1946 J.P. Frankin, M.D.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1946 at \_\_\_\_\_ M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5, 1946, to June 14, 1946

and that I last saw him live on June 14, 1946

Immediate cause of death

Pneumonia congestive  
Cardiomegaly  
Scurvy

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

with splenectomy 6/10/46 Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

J.P. Frankin, M.D. M. D. or other  
Address Cumberlands Date signed 6/17/46

RECEIVED  
JUN 25 1946  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-9

## CERTIFICATE OF DEATH

05553

Reg. Dist. No.

4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Days  
 Hospital, institution, or street address where death occurred:  
Allegany Hospital  
 How long in hospital or institution? 3 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 135 West Third St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Micheal Anthony Lagratta

## 3.(b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife.....

## 6.(c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

June 1, 1946

## 8. AGE:

Years

Months

Days

If less than one day

3

hrs.

min.

9. Birthplace Cumberland, Allegany Co., Maryland  
(Town, county, and state)

## 10. Usual occupation.....

## 11. Industry or business.....

## FATHER

## 12. Name

Anthony Lagretta

## 13. Birthplace

Indianapolis, Indiana

## MOTHER

## 14. Maiden name

Ella Grunfielder

## 15. Birthplace

New York, N. Y.

## 16. Informant

Anthony Lagratta

## Address

135 W. Third St., Cumberland, Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

6/5/46  
(month) (day) (year)

## Cemetery or crematory

St Patricks Cemetery

## Location

Cumberland, Md.

## 18. Funeral director

William H. Kight

## Address

Cumberland, Md.

## 19.

June 5, 1946  
(Date rec'd by registrar)J. P. Franklin M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1946 at 9-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1946 to June 3, 1946  
and that I last saw him alive on June 3, 1946

Immediate cause of death:

Subtotal Obstruction Entire life

Due to

Congenital abnormal rectum and anus Entire life

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Congenital abnormal rectum and anus Date of op. 6-3-46

Autopsy result

Congenital abnormal rectum and anus  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin M.D.  
Address Cumberland, Md. Date signed 6-3-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

05554

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County... AlleganyCity or town... Frostburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

286 E. Main St

How long in hospital or institution?

## 3. (a) FULL NAME

Jane Close Lemmert

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Henry Lemmert

7. Birth date of

deceased (mo., day, yr.)

March 10, 1875

8. AGE:

Years 71Months 2Days 21

If less than one day

hrs. min.

9. Birthplace Eckhart, Allegany, Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Jane Close13. Birthplace Scotland14. Maiden name Margaret Dudley15. Birthplace Scotland16. Informant George LemmertAddress Frostburg Md.17. (Burial, cremation, or removal, Which?) BurialDate thereof June 3, 1946  
(month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Frostburg, Md.18. Funeral director J. R. DuerstAddress Frostburg, Md.

19. (Date rec'd by registrar)

19. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 286 E. Main

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1946, at 9:15 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/21 1946, to 6/1 1946and that I last saw him alive on 5/31 1946Immediate cause of death Coronary ThrombosisDURATION 11 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Hilda J. Walker, M.D.Address Frostburg MdDate signed 6/3/46

UNITED STATES DEPARTMENT OF JUSTICE

HYPOCHLOREXIN

RECEIVED  
JUN 5 1946  
BUREAU V. E.

Deputy Medical Examiner - Allegany Co.

RECEIVED  
JUN 21 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Miners HospitalHow long in hospital or institution? Life

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6/5/46

8. (c) If alive, give age..... years

8. AGE:

Years 0Months 0Days 0

If less than one day

18 hrs. 0 min.

9. Birthplace

Frostburg Md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Wesley Eugene Loar13. Birthplace Loopsconing Md14. Maiden name Helen Mabel Russell15. Birthplace Barton Md16. Informant Mrs Wesley LoarAddress Barton, Md.17. Burial Date thereof 6/7/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Crematory Laurel HillLocation Westernport18. Funeral director Ellsworth BradAddress Westernport Md.19. 6/6 19 46 Wm J. M. Price  
(Date rec'd by registrar) (year) (month) (day) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Barton  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 46, at 12:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 19 46, to June 6 19 46, and that I last saw him alive on June 6 19 46.

Immediate cause of death

Permaternity

Due to

Toxemia of Mother

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

H. J. de la Jarrel M. D. or other  
Address Frostburg, Md Date signed 6/6/46



MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUN 8 1945  
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

65557

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

### 1. PLACE OF DEATH:

County... Allegany  
City or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15. Years  
Hospital, institution, or street address where death occurred:  
Sylvan Retreat  
How long in hospital or institution? 15. Years

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland County... Allegany  
City or town... Vale Summit  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rural  
(If rural, give LOCATION)  
2.(a) If veteran, name war...

### 3.(a) FULL NAME

Fannie Long

### 3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 4, 1871 8.(c) If alive, give age... years

8. AGE: Years 75 Months 3 Days 10 If less than one day... hrs. ... min.

9. Birthplace Vale Summit, Allegany Co, Maryland  
(Town, county, and state)

10. Usual occupation House

11. Industry or business 11

MOTHER 12. Name William Long,

13. Birthplace Cresaptown, Md.

14. Maiden name Altha Long

15. Birthplace Cresaptown, Md.

16. Informant Lucian Radcliffe

Address LaVale, Cumberland, Md.

17. Burial Date thereof 6/16/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Vale Summit Cemetery

Location Vale Summit

18. Funeral director William H. Kight

Address Cumberland, Md.

19. June 16, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1946 at 7:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28, 1946 to June 14, 1946 and that I last saw him live on June 13, 1946

Immediate cause of death Cerebral Hemorrhage DURATION 3 Day

Due to Generalized Arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M. D. or other

Address Cumberland Date signed 6-15-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 25 1946  
BUREAU V B

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

05558 4

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49 yrs

Hospital, institution or street address where death occurred:

13 Long Ave

How long in hospital or institution

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 13 Long Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Rosa Bell Long

## 3.(b) Social Security Number

none4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Herbert A Long

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 18968. AGE: Years 49 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Cumberland Ind.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Korschwell13. Birthplace Ind14. Maiden name Makowon

15. Birthplace

16. Informant Herbert A LongAddress Cumberland17. Burial  
(Burial, cremation, or removal. Which?)Date thereof June 11 46  
(month) (day) (year)Cemetery or crematory Abe Cem.Location Old Furnace N. Va.18. Funeral director Louis Stein IncAddress Cumberland19. June 11 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 46 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8 1946 to June 9 1946and that I last saw him alive on June 8 1946Immediate cause of death Cerebral Hemorrhage DURATION 28 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Clay E. June 10 M. D. or otherAddress Cumberland Date signed June 10 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1946

BUREAU V.S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Pittsburgh  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrs

Hospital, institution or street address where death occurred:

111 Race St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cambsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 111 Race St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Howard Taylor Mahoney

## 3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced WidowedB.(b) Name of husband or wife Katherine Hoemicka7. Birth date of deceased (mo., day, yr.) Jan 20 1879 8.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 67 Months 4 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Cambsburg Ind  
(Town, county, and state)10. Usual occupation Retired11. Industry or business Employee12. Name Katherine Mahoney13. Birthplace Ind.14. Maiden name Sarah Snyder15. Birthplace Ind.16. Informant Kenneth MahoneyAddress Cambsburg17. Burial Date thereof June 14 46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Hillcreek Cem.Location Cambsburg18. Funeral director Louis Stein IncAddress Cambsburg19. June 13 1946 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 19 46 at 10:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11, 1946 to June 11, 1946and that I last saw him alive on June 2, 1946

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton J. LyonsAddress Cambsburg M. D. or otherDate signed June 13, 1946

0200

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

RECEIVED  
JUN 18 1946  
BUREAU U.S.

ARVESTIAN DEERER

AG CONTENT



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05560

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany

City or town... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

432 Grand Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany

City or town... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 428 Arch St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Josephine Rowan McClain

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife Martin McClain

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1869

8. AGE: Years Months Days If less than one day  
76 7 16 hrs. min.

9. Birthplace Altamont, Md.  
(Town, county, and state)

10. Usual occupation Owner

11. Industry or business Boarding House

FATHER 12. Name John Rowan

13. Birthplace Ireland

MOTHER 14. Maiden name Mary Kearney

15. Birthplace Ireland

16. Informant Miss. Mary Joyce

Address 432 Grand Ave. Cumberland, Md.

17. Burial Date thereof June 22, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Patricks Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland Md.

19. June 27, 46 J. R. H. M. D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1946, at 6:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1946 to June 19, 1946 and that I last saw him alive on June 18, 1946

Immediate cause of death... Chronic Myocarditis

Due to... Chronic Myocarditis

Due to... Myocarditis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... M. D. or other

Address... Date signed June 21, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 25 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 64

## CERTIFICATE OF DEATH

05561

### 1. PLACE OF DEATH:

(a) County Allegany  
 (b) City or town Cambsalana  
 (If outside city or town limits, write RURAL and give town)  
 (c) Street address, hospital, or institution:  
659 Fayette St  
 (d) Length of stay in hospital or inst. (yrs., mos., or days) \_\_\_\_\_  
 (e) Length of stay in this community (yrs., mos., or days) \_\_\_\_\_

### 2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany  
 (c) City or town Barston  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. \_\_\_\_\_  
 (If rural give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

### 3 (a) FULL NAME

Emma Anna McDonald.

### 3 (b) If veteran, name war

### 3 (c) Social Security

No. \_\_\_\_\_

### 4. Sex

Female

### 5. Color or race

W

### 6 (a) Single, married, widowed, or divorced.

Widowed

### 6 (b) Name of husband or wife

James McDonald, Sr.

### 6 (c) If alive, give age years

### 7. Birth date of deceased (mo., day, yr.)

Aug-4-1864

### 8. AGE:

Years

Months

Days

If less than one day

81

10

17

hr.

min.

### 9. Birthplace

Firm Rock, Garrett, Maryland  
 (Town, county, and state)

### 10. Usual occupation

House wife

### 11. Industry or business

Own home

### FATHER

### 12. Name

Jesse Michaels

### 13. Birthplace

Firm Rock, Md.

### MOTHER

### 14. Maiden Name

NANCY FAZENDAKER

### 15. Birthplace

Firm Rock, Maryland

### 16 (a) Informant

Mrs. H. B. MALLEY

### (b) Address

LOTMAN ROAD, Cambsalana, Md.

### 17 (a)

BURIAL

### (b) Date thereof

23 June 1946

### (Burial, cremation, or removal)

(month) (day) (year)

### (c) Cemetery or crematory

LAUREL HILL CEMETERY

### Location

MASON, Md.

### 18 (a) Funeral director

ELLSWORTH J. BOAL

### (b) Address

111 Church St., Westport, Md.

### 19 (a)

June 23/46

### (b)

Registrar

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. Date of death June 21 1946, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1946 June 21 1946, and that I last saw him alive on June 20 1946.

### Immediate cause of death

Cerebral hemorrhage

### Duration

1 day

### Due to

arteriosclerosis

15 yr.

### Due to

### Other conditions

(Include pregnancy within 3 months of death)

### Major findings:

Of operations \_\_\_\_\_

### Of autopsy

None

### PHYSICIAN

Underline the cause to which death should be charged statistically.

### 22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide NO

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? \_\_\_\_\_ While at work? \_\_\_\_\_

(Specify type of place)

(e) Means of injury \_\_\_\_\_

### 23. Signature

J. H. Season

### Address

126 Victor St., Cambridge, Md.

### Date signed

6/21/46

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC

JUN 24 1945

BUREAU V E

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05562 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Camberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs.Hospital, institution, or street address where death occurred:  
81 Greene St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Camberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 81 Greene St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Gonzaga, McHugh

## 3. (b) Social Security Number

714-05-83014. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) about 1871 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Ind.  
(Town, county, and state)10. Usual occupation Clerk, steps store11. Industry or business Retired 5 yrs.12. Name Ann McHugh13. Birthplace Ind.14. Maiden name Ann Carney15. Birthplace Ind.16. Informant George CarneyAddress Camberland17. Burial Date thereof Jan 8 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Peter & Pauls ConLocation Camberland Ind.18. Funeral director Louis Stein IncAddress Camberland19. June 7 46 J. P. Trautman, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6- 19 46 at 2 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-15-46 19 to 6-6-46 19and that I last saw him alive on 5-1-46 19Immediate cause of death Coronary occlusion DURATION Instant

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. Trautman MD M. D. or otherAddress Camberland Ind Date signed 6-6-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

05563

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegheny  
City or town Cumtberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 yrs  
Hospital, institution, or street address where death occurred:  
Memorial Hospital  
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegheny  
City or town Cumtberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 209 Columbia St  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME

William R. Mendenhall

3.(b) Social Security Number

213-22-3566

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Yema Edminton  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) Aug 25 1864  
8. AGE: Years 81 Months 9 Days 25 If less than one day hrs. min.

9. Birthplace Sir John's Run, N. Va.  
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business cigar store

12. Name Albert Mendenhall

13. Birthplace Va.

14. Maiden name Mary J. James

15. Birthplace Ind.

16. Informant Mrs Edgar Reynolds

Address Cumtberland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 22 '46  
(month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumtberland

18. Funeral director Louis Stein Inc

Address Cumtberland

19. 6-22 19 46 J. P. Franklin, M. D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 30 19 46 at 10<sup>30</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 10 19 46 to June 28 19 46

and that I last saw him alive on June 28 19 46

Immediate cause of death Chronic nephritis

Chronic hypertensive

Due to suppurative bronchopneumonia

Due to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Mason

26 Union St Cumtberland M. D. or other

Address Date signed 6/21/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JUN 25 1946  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-3)

05564

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

20 DAYS

## 3. (a) FULL NAME

MERRBACH, JESSIE MRS.

## 3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife... MERRBACH, ROBERT

DECEASED

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

JANUARY 4, 1881

8. AGE:

Years

Months

Days

If less than one day

65

4

28

hrs.

min.

9. Birthplace...

MARYLAND

(Town, county, and state)

10. Usual occupation...

HWEE

11. Industry or business

12. Name... MATHEWS, S. GEORGE

13. Birthplace

SCOTLAND

14. Maiden name

ALTER, ANNIE

15. Birthplace

SCOTLAND

16. Informant...

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof...

June 5-46

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

June 4, 1946 J. P. Franklin, M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND

County... ALLEGANY

City or town... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 50 JACKSON ST., LONA CONING, MD.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 2, 1946, at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

7:31, 1944, to 6:21, 1946

and that I last saw him alive on June 2, 1946

Immediate cause of death

DURATION

Chronic Nephritis

Due to... Hypertension

(Anemia)

Due to...

Other conditions...

(Include pregnancy within 6 months of death)

Major findings of operations...

None

Autopsy results...

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D.

Address

Cumberland Date signed 6-3-46

MARGIN RESERVED FOR BINDING

VS A15A 9-45-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1946

BUREAU VS

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-2

## CERTIFICATE OF DEATH

05565

Reg. Dist. No. 4

### 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Memorial Hospital  
How long in hospital or institution? 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany  
City or town Cumberland Md. R.F.D.#4 Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. near Oldtown Md.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3.(a) FULL NAME

Mrs. Irene Michaels

### 3.(b) Social Security Number

None

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Nile Michaels 6.(c) If alive, give age 45 years  
7. Birth date of deceased (mo., day, yr.) Feb. 7, 1913  
8. AGE: Years 33 Months 4 Days 12 If less than one day  
hrs. min.

9. Birthplace Md. (Town, county, and state)  
10. Usual occupation housewife  
11. Industry or business  
12. Name Dorey Twigg Md.  
13. Birthplace  
14. Maiden name Lydia Schryock Md.  
15. Birthplace

16. Informant Memorial Hospital  
Address Cumberland Md.  
17. Burial Date thereof 6-21-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Spring Gap Cemetery  
Location Spring Gap, Maryland  
18. Funeral director Louis Stein Inc.  
Address Cumberland Md.  
19. June 20, 1946 J.P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 (19) 1946, at 6 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19 to 19  
and that I last saw her dead June 18 1946  
Immediate cause of death about-- DURATION  
Interbrain hemorrhage 5 days  
Due to Fracture of the skull 5 days  
Probably due to: Accidental fall, over  
Due to Court case  
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results Interbrain hemorrhage  
PHYSICIAN: Please underline the cause to which death is attributed Fractured Skull  
22. VIOLENCE: If death was due to external causes, fill in the following:  
under investigation  
Accident, suicide, or homicide Date of 6-19-46  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of Injury Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming  
M. D. or other  
Address Date signed 6/20/46  
acting Deputy Medical Examiner - Allegany Co

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 25 1946

BUREAU V S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37a)

## CERTIFICATE OF DEATH

★05566

9

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Allegany  
City or town crossed out  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 9 days  
Hospital, institution, or street address where death occurred: Mannors Hospital  
How long in hospital or institution? 9 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Midland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1  
(If rural, give LOCATION)  
2.(a) If veteran, name war No

### 3. (a) FULL NAME

Enoch Miller

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife none 6. (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) April 6, 1872

8. AGE: Years 74 Months 2 Days 23 If less than one day hrs. min.

9. Birthplace Facoma, Davis Int. Louisiana  
(Town, county, and state)

10. Usual occupation Local Miner - Retired

11. Industry or business Midland Mining Co.

12. Name Henry Miller

13. Birthplace unknown

14. Maiden name Elizabeth Dickie

15. Birthplace unknown

16. Informant Clarence Miller

Address Midland, Md.

17. Burial Date thereof July 1, 1946  
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Lawson Hill Cemetery

Location Moscow Rd

16. Funeral director M. C. Ciphors

Address Facoma, Md.

19. 7-1 19 46 Ms. Halsey & Co.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20, 1946 to June 29, 1946

and that I last saw him alive on June 29, 1946

Immediate cause of death Cardio-vascular renal disease

Due to arterio-sclerosis

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations X

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of June 29, 1946

Where did injury occur? Midland, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Midland, Md.

Means of injury none Injured at work? none

23. SIGNATURE H. C. Licht, M.D.

Address Frostburg, Md. Date signed 6/30/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 3 1946  
BUREAU V S.



Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1126

05567

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 27 Years  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 1 Hour

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Near Cumberland Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural #3  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Montgomery

## 3. (b) Social Security Number

214-05-9553

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Anetta Montgomery6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) May 1 - 1875

8. AGE: Years Months Days If less than one day  
71 1 8 hrs. min.

9. Birthplace Westernport, Allegany Co., Maryland  
(Town, county, and state)10. Usual occupation Lumberman11. Industry or business Penna Lumber Post Co12. Name Eugene Montgomery13. Birthplace Springfield, W. Va14. Maiden name Unknown Porter15. Birthplace Hampshire Co., W. Va.16. Informant Mrs. Charles H. MontgomeryAddress Rt. 3, Cumberland, Md.17. Burial Date thereof 6/12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland, Md.16. Funerary director William H. KnightAddress Cumberland, Md.

June 12, 1946 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1946 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19 to 19  
 and that I last saw him alive on June 9 1946

Immediate cause of death Cardiac dilatationDue to Bronchial Asthma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M. D. or other

Address Date signed

Acting Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1946

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1240

05568

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

640 N. Center Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 640 N. Center Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

CLIFFORD SHELTON MYERS

## 3. (b) Social Security Number

214-05-47714. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Myrtle (Lambarta) Myers6. (c) If alive, give age 50 years7. Birth date of deceased (mo., day, yr.) Jan. 13, 18868. AGE: Years 60 Months 5 Days 10 If less than one day  
.....hrs. ....min.9. Birthplace Sharpsburg, Washington, Maryland  
(Town, county, and state)10. Usual occupation Drivers Helper11. Industry or business Cumberland Brewing Company12. Name Samuel Myers13. Birthplace Sharpsburg, Md.14. Maiden name Margaret GRAY15. Birthplace Sharpsburg, Md.16. Informant Mrs. Myrtle MyersAddress 640 N. Center St. Cumberland, Md.17. Burial Date thereof June 26, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Samples Manor CemeteryLocation Dargan, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. June 26, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1946 at 4:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
9 a.m. 46 to 23 June 46  
and that I last saw him alive on 17 June 46

Immediate cause of death

Embolus from (Pulmonary)  
Coronary Heart Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

W. A. Van Dine  
1105 Center St  
Cumberland, Md.  
M. D. or other  
Date signed 24 June 46

MARGIN RESERVED FOR BINDING

VS A15 9-4544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

10000

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD RECEIPT

RECEIVED

JUL 5 1948

BUREAU V.S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 055694  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County... Allegany  
City or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 yrs  
Hospital, institution, or street address where death occurred:  
Memorial Hospital  
How long in hospital or institution? 3 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... MD County... Allegany  
City or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 409 Winner St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mrs Mary Naylor

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John Naylor

7. Birth date of deceased (mo., day, yr.) Aug 18, 1870 6.(c) If alive, give age years

8. AGE: Years 75 Months 10 Days 1 If less than one day hrs. min.

9. Birthplace Longsoring, Allegany Co, Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

12. Name James Graham

13. Birthplace Scotland

14. Maiden name Margaret Robinson

15. Birthplace Scotland

16. Informant Wm Graham Schell

Address 609 Park St - Connellsville Pa

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 22, 1946  
(month) (day) (year)

Cemetery or crematory Ross Hill Cemetery  
Location Cumberland, Md

18. Funeral director John J. Hafer  
Address Cumberland, Md.

19. June 21, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 46 at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 19 46 to June 18 19 46  
and that I last saw him alive on June 19 19 46

Immediate cause of death

Uremia

Due to Chronic Nephritis

Due to

Other conditions Cellulitis of arm

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D.  
M.D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

JUN 25 1946

BUREAU VS

CERTIFICATE OF DEATH

05570

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 612 FAIRVIEW AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

PEEBLES, LUCY MRS.

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

MARRIED

6. (b) Name of husband or wife... PEEBLES, JAMES D.

8. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 13 1876

8. AGE: Years Months Days If less than one day  
69 6 26 hrs. min.

9. Birthplace... MARYLAND - MOSCOW  
(Town, county, and state)

10. Usual occupation... HOUSE WIFE

11. Industry or business

12. Name... CORFIELD, WILLIAM

13. Birthplace... ENGLAND

14. Maiden name... TOOTH, PATIENCE

15. Birthplace... ENGLAND

16. Informant... James Corfield

Address... Cumberland Ind

17. Burial Date thereof... June 9 46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Hillcrest Cem

Location... Cumberland

18. Funeral director... Louis Stein Inc

Address... Cumberland

19. June 8, 1946 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 6, 1946 at 7:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 1946 to June 6, 1946

and that I last saw her alive on June 6, 1946

Immediate cause of death

Cerebral Embolism

DURATION

5 yrs

Myocarditis

5 yrs

Due to

Chromia

6 wks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature... Clay J. Jones

Address... Cumberland

23. SIGNATURE... Clay J. Jones

Address... Cumberland

Date signed... June 7, 1946

MARGIN RESERVED FOR BINDING

VS. A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JUN 11 1946  
BUREAU V.S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 9 hours 35 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 120 Springdale Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Helen V. Poland

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1945

8. AGE: Years Months Days If less than one day

0 11 20 hrs. min.9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

12. Name Melvin Poland13. Birthplace West Virginia14. Maiden name Gladys Haenftling15. Birthplace West Virginia16. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial Date thereof June 12, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director John J. HoferAddress Cumberland, Md.19. June 12, 1946 J. S. Franklin, M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 46 at 4:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 7, 1946 to June 9, 1946and that I last saw him alive on June 9, 1946

Immediate cause of death

Status: Myocardiallymphatic

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M.E.B. Owens, M.D.Address 133 Va aveDate signed 6/14/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (570)

## CERTIFICATE OF DEATH

05572

★ Reg. Dist. No. 9

### 1. PLACE OF DEATH:

County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Miners Hospital  
How long in hospital or institution? 3 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mary Louise Rank

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) June 22, 1946 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 3 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Frostburg, Allegany, Md.  
(City, county, and state)

10. Usual occupation \_\_\_\_\_

### 11. Industry or business

12. Name Walter Rank

13. Birthplace Maryland

14. Maiden name Mabel Howell

15. Birthplace Maryland

16. Informant Mrs. Mary Yates

Address Frostburg Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date there June 27, 1946  
(month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director J. P. Durbet

Address Frostburg Md.

19. 6-26 1946 (Date rec'd by registrar) Mrs. Quincy D. Rank Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1946 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1946, to June 26 1946 and that I last saw him alive on June 25 1946

Immediate cause of death Congenital Hydrocephalus  
in special Birth DURATION 4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wm. Lane Jr. M.D.

June 26 1946 Date signed Frostburg Md.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JUN 28 1946

BUREAU V.B.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 SOUTH STATION

2.(a) If veteran, name war

3. (a) FULL NAME

RATKE, BABY BOY

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE

WHITE

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

JUNE 24, 1946

8. AGE: Years Months Days If less than one day

N.B.

10 hrs. min.

9. Birthplace Cumberland, Allegany Co., Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal

(Which?)

Date thereof June 25, 1946  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. June 25, 1946  
(Date rec'd by registrar)

J. P. Franklin, M.D.  
Registrar

MEDICAL CERTIFICATION

10:25 P.M.

20. DATE OF DEATH JUNE 24, 1946 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24 1946 to June 24 1946  
and that I last saw him alive on June 24/46 19

Immediate cause of death

Prematurity

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Cumberland, Md. Date signed July 24/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 5 1946  
BUREAU V.E.



Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

05574

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Crumbsland (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, institution, or street address where death occurred:  
La Vale - Rt. 40 - W.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Crumbsland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 113 Harrison St.  
(If rural, give LOCATION)  
2.(d) If veteran, name war

3. (a) FULL NAME

Mrs Anna S. Reynolds

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife J. Wm. Reynolds

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 10 1878

8. AGE: Years Months Days If less than one day  
67 11 17 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Crumbsland Ind.  
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business at Home

12. Name Wm. Gordon

13. Birthplace Ireland

14. Maiden name Catherine Donohue

15. Birthplace Ireland

16. Informant Roy G. G. G.

Address La Vale

17. Burial Date thereof 6-29-46  
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory St. Patricks Cem.

Location Crumbsland Ind.

18. Funeral director Louis Stein Inc.

Address Crumbsland

19. 6-28- 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1946 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw her at home \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Coronary occlusion

Due to \_\_\_\_\_ DURATION Immediate

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work?

23. SIGNATURE N. V. Fleming M.D. M. D. or other

Address 125 Bedford St. Date signed 6/27/46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 5 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1272

05575

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

77

8

29

.....hrs.

.....min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

18. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

19. 46

Inss. J. M. Buice

Register

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

19. 46

at.....

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3

19. 46

to June 5

19. 46

and that I last saw him alive on June 5

19. 46

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

RECEIVED  
JUN 10 1946  
BUREAU OF

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 56 yrs.

Hospital, institution, or street address where death occurred:

635 Lincoln St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 635 Lincoln St.  
(If rural, give LOCATION)2(a) If veteran, name war I World War

## 3. (a) FULL NAME

J. Henry Schrade

## 3. (b) Social Security Number

715-12-20814. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Irma Miller7. Birth date of deceased (mo., day, yr.) Feb 6 1890 B. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 56 Months 4 Days 1 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Cumberland Ind.  
(Town, county, and state)10. Usual occupation Trimmer - Auto11. Industry or business Industry12. Name Nicholas Schrade13. Birthplace Germany14. Maiden name Elizabeth D. Schrade15. Birthplace Ind.16. Informant Herman SchradeAddress Cumberland17. Burial (Burial, cremation, or removal, Which) Burial Date thereof June 9 46  
(month) (day) (year)Cemetery or crematory Hillcrest Cem.Location Cumberland18. Funeral director Logis Stein 9thAddress Cumberland19. June 8 19 46 Jos. P. Franklin, M.D. Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-46 at 8 am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-3-46 to 6-7-46and that I last saw him alive on 5-29-46Immediate cause of death Acute Myeloid LeukemiaDURATION 4 1/2 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wm. F. Williams M. D. or other \_\_\_\_\_Address Cumberland Date signed 6-7-46

RECEIVED

JUN 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05577

Reg. Dist. No. 4

## 1. PLACE OF DEATH

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 1 week

## 3. (a) FULL NAME

Boris Elaine Baby Girl Shaffer

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 20, 1946

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

7

hrs.

min.

9. Birthplace

Cumberland, Allegheny, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 46

J. P. Franklin, M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Pennia

County

Bedford

City or town

Hyndman  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 19 46 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20 19 46 to June 27 19 46and that I last saw her alive on June 26 19 46

Immediate cause of death

Erythras blastosis  
Foetatus

DURATION

7 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Fopper MD  
Hyndman Pa

M. D. or other

Address

Date signed 6/28/46



RECEIVED  
JUL 5 1946  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of the  
age of deceased is shown on MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

05578

Reg. Dist. No. 9

FILM No. I O 4 JUN 10 1946

# CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Allegheny  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 28 yrs  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Ind. County Allegheny  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. P. O. Box 299  
(If rural, give LOCATION)  
2. (a) If veteran, name war

## 3. (a) FULL NAME

Sarah Elizabeth Skidmore

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Elijah Skidmore

T. Birth date of deceased (mo., day, yr.) Oct. 27th 1860 6. (c) If alive, give age..... years

8. AGE: Years 85 Months 4 Days 7 If less than one day..... hrs. .... min.

9. Birthplace Frostburg, Allegheny, Ind.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm. P. Meyer

13. Birthplace Frostburg, Ind.

14. Maiden name Elizabeth Skidmore

15. Birthplace Frostburg, Ind.

16. Informant Wm. P. Meyer

Address P. O. Box 299 Frostburg Ind.

17. Burial Date thereof 6-3-1946  
(Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory Southern Cemetery

Location Frostburg, Ind.

18. Funeral director David Wagner

Address Frostburg, Ind.

19. (Date rec'd by registrar) 19.....

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1946, at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1946 to June 1 1946

and that I last saw him alive on June 1 1946

Immediate cause of death Cerebral Hemorrhage

PT. Hemiplegia

Due to Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. P. Meyer M. D. or other

Address Frostburg Ind. Date signed June 2/46

RECEIVED  
JUN 5 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

05579

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County alliganyCity or town Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Margaret Smith

7. Birth date of deceased (mo., day, yr.)

March 8 - 1885

8. (c) If alive, give age

70

8. AGE:

Years

Months

Days

If less than one day

61

3

1

hrs.

min.

9. Birthplace

Elk Garden, W. Va.

(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

Elk Garden, W. Va.

FATHER

12. Name

Joseph Smith

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Agnes Clayton

15. Birthplace

W. Va.

16. Informant

Mrs. Margaret Smith

Address

Smithsburg, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 11 - 1946

Cemetery or crematory

alligany

Location

Smithsburg

18. Funeral director

Address

Smithsburg, Md.

19.

(Date rec'd by registrar)

19.

46 Mrs. Nancy A. Ro

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md.

County

alligany

City or town

Smithsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

153 E. Loc

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

213-01-5955

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 9

19

46, at 3:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4

19

to June 9

19

46

and that I last saw him alive on

June 8

19

46

Immediate cause of death

Coronary Thrombosis

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. M. Lane, M.D.

M. D. or other

Address

Smithsburg, Md.

Date signed 6-10-46

RECEIVED

JUN 13 1946

BUREAU V.S.

Within corporate limits

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

05580

Reg. Dist. No. 4

1. PLACE OF DEATH:  
County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? \_\_\_\_\_  
Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
How long in hospital or institution? 42 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State PENNSYLVANIA County BEDFORD  
City or town BEDFORD VALLEY  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
MRS. GERTRUDE SNYDER

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife WARREN A. SNYDER

8. (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) DEC. 22, 1895

8. AGE: Years 70 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace PENNSYLVANIA, Bedford County  
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

12. Name FRANK DIEHL

13. Birthplace PENNSYLVANIA, Bedford County

14. Maiden name LOUISE STIVER

15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof June 15, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Park

Location Bedford, Penna.

18. Funeral director Fred C. Tate

Address Bedford, Penna.

June 13, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 13, 1946 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5. 2. 1946 to 6. 13. 1946

and that I last saw him alive on 6. 12. 1946

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Carcinoma of stomach with metastasis to liver & regional lymph nodes

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

W. F. Williams

23. SIGNATURE \_\_\_\_\_ M. D. \_\_\_\_\_

Address Cumberland Date signed 6.13.46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF THE ARMY

HEADQUARTERS

RECEIVED

JUN 18 1946

BUREAU V S



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 770

05581

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 427 Independence Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

PERCY E. SOWERS

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Christina Brown

7. Birth date of

deceased (mo., day, yr.)

February 14, 1900

8. (c) If alive, give age 43 years

8. AGE:

46

Years

Months

4

Days

14

If less than one day

hrs.

min.

9. Birthplace

Clear Ridge, Penna.

(Town, county, and state)

10. Usual occupation

Shoe Repairman

11. Industry or business

Own

FATHER

12. Name

John E. Sowers

13. Birthplace

Penna.

MOTHER

14. Maiden name

Genevieve Houser

15. Birthplace

Penna.

16. Informant

Mrs. Christina Sowers

Address 427 Independence St., Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 30, 1946  
(month) (day) (year)

Cemetery or crematory

Zion Memorial Park

Location

Cumberland, Maryland

18. Funeral director

William H. Kight

Address

Cumberland, Maryland

19. June 30, 1946

(Date rec'd by registrar)

J. P. Frankler, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1946 at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 23 1946 to June 28 1946  
or that I last saw him alive on June 28 1946

Immediate cause of death

DURATION

Cerebral Oedema.

Due to

Due to

Chr. Alcoholism (?)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. H. Cleaver, M.D.

M. D. or other

Address

49 Greene St.

Date signed

6-29-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HEALTH OF THE UNITED STATES

CERTIFICATE OF DEATH

RECEIVED  
JUL 5 1946  
BUREAU V.S.

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

05582

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 33 Years  
 Hospital, institution, or street address where death occurred:  
211. Beall St  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 211. Beall St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Joseph Edward Speicher

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Agnes Speicher6. (c) If alive, give age 75 years

## 7. Birth date of deceased (mo., day, yr.)

April 19 1869

## 8. AGE:

77

Years

Months

1

Days

17

If less than one day

hrs.

min.

## 9. Birthplace

McHenry, Garrett Co, Maryland  
(Town, county, and state)

## 10. Usual occupation

Labor

## 11. Industry or business

Celenese Corporation

## FATHER

## 12. Name

Joseph A. Speicher

## 13. Birthplace

New Germany, Md.

## MOTHER

## 14. Maiden name

Sarah Hershberger

## 15. Birthplace

Westmoreland Co, Penna

## 16. Informant

Mrs. Joseph E. Speicher

## Address

211. Beall St, Cumberland, Md.

## 17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

6/9/46

(month) (day) (year)

## Cemetery or crematory

Philos Cemetery

## Location

Westernport, Md.

## 18. Funeral director

William H. Kight

## Address

Cumberland, Md.

## 19.

(Date rec'd by registrar)

June 8, 1946J.P. Tankhi, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1946 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
1 May 46 1946 to 6 June 46 1946  
 and that I last saw him alive on 3 June 46 1946

## Immediate cause of death

Cerebro-vascular accident

## DURATION

1 week

## Due to

arterio-sclerosis  
recurrent cerebro-vascular  
accidents past 7 years.

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Dine M. D. or otherAddress Cumberland, Md Date signed 7 June 46

RECEIVED

JUN 11 1946

BUREAU V.S.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 23 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANYCity or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 404 GRAND AVE. CITY  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

FLOYD SPONAUGLE

## 3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 19468. AGE: Years Months Days If less than one day  
1 17 hrs. min.9. Birthplace... CUMBERLAND, MARYLAND  
(Town, county, and state)10. Usual occupation... Infant

11. Industry or business

12. Name... BOYD SPONAUGLE13. Birthplace... W.VA.14. Maiden name... SARAH WALKER15. Birthplace... W.VA.16. Informant... MEMORIAL HOSPITALAddress... Cumberland, Md.17. Burial Date thereof... June 11, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Greenmount CemeteryLocation... Cumberland, Md.18. Funeral director... William H. KightAddress... Cumberland, Md.June 11, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 9 1946 at 6:20A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to 1946and that I last saw him alive on 6-8- 1946

Immediate cause of death

Sudden Infant DeathDue to Congenital

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. W. BensonAddress... 126 Greenmount Cemetery M. D. or otherDate signed 9/9/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

JUN 18 - 1945

BUREAU V.B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05584

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? two years

Hospital, institution, or street address where death occurred:

445 N. Center St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 445 N.Center  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Henry Stair

## 3. (b) Social Security Number

191-01-2430

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Irma Koontz Stair6. (c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) April 14 18908. AGE: Years 56 Months 2 Days 3 If less than one day  
..... hrs. .... min.9. Birthplace Huntington Pa.  
(Town, county, and state)10. Usual occupation Advertising salesman

11. Industry or business

12. Name John Stair13. Birthplace Huntington Pa.14. Maiden name Maud Meyers15. Birthplace Huntington Pa.16. Informant Mrs Irma K. StairAddress 445 N.Center St Cumberland Md.17. Burial Date thereof June 22-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation Friend's Cove, Bedford Co. Pa.18. Funeral director Hafer Funeral ServiceAddress Cumberland Md.19. June 22 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

about June 17 19 46 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46, to 19 46and that I last saw him alive on June 19 19 46

Immediate cause of death

Coronary occlusion

## DURATION

immediatDue to Angina Pectoris attacks 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or other

Address Date signed

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 25 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County..... AlleganyCity or town..... Carlos  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... AlleganyCity or town..... Carlos  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lillian Elizabeth Stevenson

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

George Stevenson

## 7. Birth date of deceased (mo., day, yr.)

February 18, 1882

## 8. AGE:

Years 64 Months 3 Days 15  
If less than one day ..... hrs. .... min.

## 9. Birthplace

Frostburg, Allegany, Md.  
(Town, county, and state)

## 10. Usual occupation

housewife

## 11. Industry or business

home

## FATHER

12. Name..... George Adams13. Birthplace..... England14. Maiden name..... Edith Griffith15. Birthplace..... England16. Informant..... Mrs. Edith HutchersonAddress..... Carlos, Md.

## 17. Burial

(Burial, cremation, or removal. Which?) Burial Date thereof June 5, 1946  
(month) (day) (year)Cemetery or crematory..... Allegany CemeteryLocation..... Frostburg, Md.18. Funeral director..... J. R. HurstAddress..... Frostburg Md.19. 6/4 46 J. M. Price  
(Date rec'd by registrar) (year) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 2 1946, at 8:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Carcinoma of  
RT Breast

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?.....

23. SIGNATURE..... Wm Lane Jr MD M. D. or otherAddress..... Frostburg Md. Date signed 6-4-46

RECEIVED

JUN 7 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 15586 5 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County..... Allegany		(For newborn infants give residence of mother)	
City or town..... Rawlings, Md. near Cumberland		State..... Maryland County..... Allegany	
(If outside city or town limits, write RURAL and give nearest town)		City or town..... Rawlings near Cumberland,	
How long in above place of death?..... 25 Yrs.		(If outside city or town limits, write RURAL and give nearest town)	
Hospital, institution, or street address where death occurred:		Street No..... Rawlings near Cumberland,	
Rawlings, Md.		(If rural, give LOCATION)	
How long in hospital or institution?.....		2.(a) If veteran, name war.....	

3. (a) FULL NAME	3. (b) Social Security Number
Mordecai Preston Summerfield	None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married
6. (b) Name of husband or wife..... Martha Waybright		
6. (c) If alive, give age..... 78 years		
7. Birth date of deceased (mo., day, yr.)..... Mar. 25, 1864		
8. AGE:	Years	Months
82	2	29
It less than one day..... hrs. .... min.		

9. Birthplace.....	Harmon, W. Va.
(Town, county, and state)	
10. Usual occupation.....	Carpenter
11. Industry or business.....	Contracting business
FATHER	12. Name..... John W. Summerfield
13. Birthplace.....	Randolph Co. W. Va.
MOTHER	14. Maiden name..... Mary C. Roy
15. Birthplace.....	Randolph Co. W. Va.
16. Informant.....	Alfred S. Summerfield
Address..... Rawlings, Md.	

17. Burial	Date thereof..... June 27, 1946
(Burial, cremation, or removal. Which?)	(month) (day) (year)
Cemetery or crematory.....	Rose Hill Cem.
Location.....	Cumberland, Md.
18. Funeral director.....	H. Wayne George
Address..... Cumberland, Md.	

19. June 27, 46	Registrar
(Date rec'd by registrar)	

MEDICAL CERTIFICATION	
20. DATE OF DEATH.....	June 24, 1946 3:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 May 1946 to 24 June 1946 and that I last saw him alive on 24 June 1946	
Immediate cause of death.....	DURATION
① BRONCHOPNEUMONIA	1 wk.
② INTESTINAL OBSTRUCTION	2 wk.
Due to ③ NEOPLASM OF INTESTINE	?
④ Secondary Hepatic Neoplasia	1 mo.
Due to.....	
Other conditions.....	PARKINSON'S DISEASE 18 Mos.
(Include pregnancy within 8 months of death)	
Major findings of operations.....	No
Autopsy results.....	No
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide.....	Date of.....
Where did injury occur?.....	(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....	
Means of injury.....	Injured at work?
23. SIGNATURE.....	Harold G. Weismann MD
M. D. or other	
Address.....	Croftown
Date signed..... 25 June 1946	

RECEIVED

JUL 31 1946

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

CERTIFICATE OF DEATH

05587 4  
Reg. Dist. No.

1. PLACE OF DEATH:

County... ALLEGANY  
City or town... CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? From 21 days  
Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
How long in hospital or institution? 1 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY  
City or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
12 LAING AVE. (1018 ELLA ST.)  
Street No. OLD ADDRESS (If rural, give LOCATION)  
2.(a) If veteran, name war...

3. (a) FULL NAME

SWICK, THOMAS Thomas S. Swick

3. (b) Social Security Number

None

4. Sex 5. Color of race 6. (a) Single, married, widowed, or divorced

MALE WHITE SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) DEC. 18 1945  
8. AGE: Years Months Days If less than one day

6 MONTHS 5 21 hrs. min.

9. Birthplace... WEST VIRGINIA  
(Town, county, and state)

10. Usual occupation... INFANT

11. Industry or business

12. Name... MELVIN C. SWICK

13. Birthplace... WEST VIRGINIA

14. Maiden name... ADA SMITH

15. Birthplace... WEST VIRGINIA

16. Informant... MELVIN SWICK

Address... 1018 ELLA ST. CUMBERLAND, MD.

17. Burial Date thereof... June 17 46  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory... Greenleaf Cem

Location... Cumberland, Md.

18. Funeral director... Louis Stein Inc

Address... Cumberland

19. June 11, 1946 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH... JUNE 9, 1946 19... at... 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4<sup>th</sup> 1946 to June 9<sup>th</sup> 1946  
and that I last saw him... alive on... 19...

Immediate cause of death

Congenital Endocarditis

Due to...

Chronic Bronchitis

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J. P. Franklin, M.D. M. D. or other

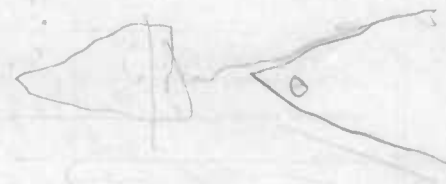
Address... Cumberland, Md Date signed... 6-10-46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 18 1946  
BUREAU V.B.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

05588

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
City or town Crimm Island  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4.5 yrs

Hospital, institution, or street address where death occurred:

761 Fayette St.How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Crimm Island  
(If outside city or town limits, write RURAL and give nearest town)Street No. 650 Fayette St.  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

Bruce Wagh Thomas

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Edison ThomasB. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Oct 14 18638. AGE: Years 82 Months 7 Days 19 If less than one day — hrs. — min.9. Birthplace Baltimore Co Ind.  
(Town, county, and state)10. Usual occupation —11. Industry or business —12. Name John Wagh Ind.13. Birthplace Ind.14. Maiden name Margaret Disney15. Birthplace Ind.16. Informant Mrs E. T. NixonAddress Crimm Island17. Burial Date thereof June 6 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemLocation Crimm Island18. Funeral director Yoris Stein Inc.Address Crimm Island19. June 6 19 46 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 46 at 130 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 46 to June 3 46and that I last saw him alive on June 1 19 46Immediate cause of death several arteriosclerosis

DURATION

Due to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —23. SIGNATURE W. P. Hodge, M. D.M. D. or other —Address Crimm Island Md Date signed 6-4-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

05589

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County... Allegany  
 City or town... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 67 years  
 Hospital, institution, or street address where death occurred:  
RFD # 1  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Allegany  
 City or town... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... RFD # 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

William Henry Tippen

## 3. (b) Social Security Number

720-10-2753

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
6.(b) Name of husband or wife... <u>Ella S. Tippen</u>		
8.(c) If alive, give age <u>59</u> years		
7. Birth date of deceased (mo., day, yr.) <u>Aug. 9 1878</u>		
8. AGE: Years <u>67</u>	Months <u>9</u>	Days <u>22</u> If less than one day .....hrs. ....min.

9. Birthplace... Frostburg-Allegany-Md.  
 (Town, county, and state)  
 10. Usual occupation... Miner  
 11. Industry or business... Coal-Miner

MOTHER	12. Name... <u>James Tippen</u>
	13. Birthplace... <u>Pottsville, Pa</u>
	14. Maiden name... <u>Anna Morgon</u>
15. Birthplace... <u>Mt. Savage, Md.</u>	

16. Informant... Mrs. Ella Tippen  
 Address... Frostburg, Md.  
 17. Burial Date thereof... June 3, 1946  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory... St. Michaels Cem.  
 Location... Frostburg, Md.  
Ellsworth S. Boal,  
 18. Funeral director...  
 Address... Westernport, Md.

19. (Date rec'd by registrar) 19. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 1, 1946 19. at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1946 to June 1 1946  
 and that I last saw him alive on May 31 1946

Immediate cause of death... Coronary Thrombosis  
 Due to...  
Arterio Sclerosis  
 Other conditions...  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... Wm C Lane MD. M. D. or other  
 Address... Frostburg Md. Date signed... 6-3-46

DURATION

Sudden  
several  
years

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JUN 5 1946

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 556

05590

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 years  
 Hospital, institution, or street address where death occurred:  
13 Arch St  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 13 Arch St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Kathryn Jean Lee Troutman

## 3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 16, 1932

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1362

hrs. min.

9. Birthplace

Cumberland Allegheny, Md  
(Town, county, and state)

10. Usual occupation

school

11. Industry or business

FATHER

12. Name

Holly Hite

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Marie Troutman

15. Birthplace

Cumberland, Md

16. Informant

Mrs. Marie StachursAddress 13 Arch St. Cumberland, Md

17.

(Burial, cremation, or removal. Which?)

BurialDate thereof June 21, 1946  
(month) (day) (year)

Cemetery or crematory

Greenmount

Location

Cumberland, Md.

18. Funeral director

Phy J. Hoffer

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

June 21, 1946  
J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1946 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1946 to June 15 1946  
and that I last saw him alive on June 15 1946

Immediate cause of death

Septicemia from  
sarcoma of bone  
(left femur)

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Sarcoma  
Date of op. 3/25/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

West Bldg.  
Address West Bldg. Date signed 6/20/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 25 1946

BUREAU V S

Within corporate limits  
Trevaski's

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore (83-a)  
CERTIFICATE OF DEATH

05591

Reg. Dist. No. 4

1. PLACE OF DEATH:  
County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 years  
Hospital, institution, or street address where death occurred:  
451 Walnut St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 451 Walnut St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME  
David L. Warnick

3.(b) Social Security Number  
None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced  
Widowed

6.(b) Name of husband or wife Rosa Warnick

7. Birth date of deceased (mo., day, yr.) May 5, 1862 6.(c) If alive, give age..... years

8. AGE: Years 84 Months 1 Days 11 If less than one day..... hrs. .... min.

9. Birthplace Garrett Co. Maryland  
(Town, county, and state)

10. Usual occupation Labor Foreman

11. Industry or business City of Cumberland

12. Name Jackson Warnick

13. Birthplace Unknown

14. Maternal name Mary Williams

15. Birthplace England

16. Informant Mrs. Elizabeth Scott

Address 451 Walnut St., Cumberland

17. Burial (Burial, cremation, or removal, Which?) Date thereof June 19, 1946  
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director J. P. Franklin

Address Cumberland, Md.

19. June 19 19 46 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 19 46 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 to June 16 19 46  
and that I last saw him alive on June 14 19 46

Immediate cause of death Cerebral Hemorrhage DURATION 9 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. M. Trevaskis, Sr. M.D.  
M. D. or other

Address Cumberland, Md. Date signed 6/17/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RELEASE TO THE PUBLIC BY THE BUREAU OF THE NATIONAL ARCHIVES

RECEIVED

RECEIVED

JUN 25 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 115 Oak Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Alexander Francis Washington Stevenson

## 3. (b) Social Security Number

216-22-7208

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mary P. Cole

## 7. Birth date of deceased (mo., day, yr.)

Jan. 2, -1891

## 6. (c) If alive, give age

52 years

## 8. AGE:

Years

Months

Days

If less than one day

6352hrs.min.

## 9. Birthplace

Cumtland Allegany Md  
(Town, county, and state)

## 10. Usual occupation

Caretaker

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Alexander F. Washington

## 13. Birthplace

Leont Knapp

## 14. Maiden name

Mary P. Stewart

## 15. Birthplace

Leont Knapp

## 16. Informant

Mrs. Elbert Mason

## Address

97 Chestnut St. Frostburg, Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

6-6-1946  
(month) (day) (year)

## Cemetery or crematory

Allegany

## Location

Frostburg

## 18. Funeral director

Sam J. Baker

## Address

Frostburg, Md.

## 19.

(Date rec'd by registrar)

6/61946J. M. PriceActing Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1946, at 12:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 14 1946, to June 3 1946and that I last saw him alive on June 1 1946

Immediate cause of death

Chronic myocarditis

DURATION

severalyears

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. M. Stone

M. D. or other

Address

Frostburg Md.

Date signed

6-5-46

RECEIVED

JUN 7 1946

BUREAU V.S.

CERTIFICATE OF DEATH

05593

Reg. Dist. No. 4

1. PLACE OF DEATH  
County... ALLEGANY  
City or town... CUMBERLAND MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 yrs  
Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... MARYLAND County... ALLEGANY  
City or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 513 AVIRETT AVE.  
(If rural, give LOCATION)  
2.(a) If veteran, name war...

3. (a) FULL NAME  
JOHN OLIVER WATERS

3. (b) Social Security Number  
579-12-0760A

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 30, 1946 4:50 A.M.

6. (b) Name of husband or wife... MARIA A. SHEA

21. I CERTIFY that death occurred on the date above stated; that attended deceased from 6-10-46 to 6-30-46

7. Birth date of deceased (mo., day, yr.) MARCH 16 1866

and that I last saw him alive on 6-29-46

8. AGE: Years 80 Months 3 Days 14 If less than one day hrs. min.

Immediate cause of death Carcinoma prostatic DURATION ?

9. Birthplace... Washington, D.C. (Georgetown)

Due to...

10. Usual occupation... RETIRED

Due to...

11. Industry or business Plumber

Other conditions Arteriosclerosis

12. Name JOHN A. WATERS

(Include pregnancy within 3 months of death)

13. Birthplace Washington, D.C.

Major findings of operations...

14. Maiden name MARGARET CHAMBERLAIN

Date of op. ...

15. Birthplace Washington, D.C.

Autopsy results...

16. Informant THERESA DOWNEY

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Address 513 AVIRETT AVE. CUMBERLAND, MD

22. VIOLENCE: If death was due to external causes, fill in the following:

17. Removal & Burial Date thereof 7-7-46

Accident, suicide, or homicide... Date of ...

Cemetery or crematory St. Olives Cem

Where did injury occur? (City or town) (County) (State)

Location Washington, D.C.

Injured at home, farm, industry, public place (where?)

18. Funeral director Lois Stein Inc.

Means of Injury Injured at work?

Address Cumberland Ind.

23. SIGNATURE Howard L. Tolson M. D. or other

19. July 1, 46 J. P. Faulkner, M.D. Registrar

Address Cumberland, Md Date signed 7-1-46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1946

BUREAU V.B.

Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05594

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Rural - Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Rt # 4 Uhl Hwy

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Cumberland Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. RFD # 4 Uhl Hwy  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Julia Elizabeth Wheeler

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife John Davis Wheeler

7. Birth date of deceased (mo., day, yr.) Dec 3 1890 6. (c) If alive, give age years

8. AGE: Years 55 Months 6 Days 19 If less than one day hrs. min.

9. Birthplace Darlington Co. S. Carolina  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name M. G. Flowers

13. Birthplace S. C.

14. Maiden name Sally P. Adams

15. Birthplace S. C.

16. Informant John D. Wheeler

Address Cumberland Ind

17. Burial Date thereof 6-25-46  
(Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory St. Marys Cem

Location Uhl Hwy Cumberland

18. Funeral director Donis Stein Inc

Address Cumberland

June 25, 1946 J. P. Hanklin M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1946 at 2:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/15/46 1946 to 6/22/46 1946 and that I last saw him alive on 6/15/46 1946

Immediate cause of death Coronary occlusion

Due to 1

Due to

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John N. Rozum M.D. M. D. or other

Address Cumberland Ind Date signed 6/24/46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 5 1946  
BUREAU



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *8*

## 1. PLACE OF DEATH:

County *Allegany*  
 City or town *Garadonings, Md*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *2 years 10 mos 3 das*  
 Hospital, institution, or street address where death occurred:  
*35 Church Street*  
 How long in hospital or institution? *1*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State *Maryland* County *Allegany*  
 City or town *Garadonings*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *35 Church Street*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

*Emily Morgan Whitfield*

## 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

8. (b) Name of husband or wife *Ellis P. Whitfield*

6. (c) If alive, give age *856* years

7. Birth date of deceased (mo., day, yr.) *Aug 7, 1893*

8. AGE: Years *52* Months *10* Days *3* If less than one day  
 .... hrs. .... min.

9. Birthplace *Garadonings, Allegany Co., Md.*  
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *Own home*

12. Name *Hubert Morgan*

13. Birthplace *England*

14. Maiden name *Marian Wright*

15. Birthplace *England*

16. Informant *Ellis P. Whitfield*

Address *Garadonings, Md.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *June 13, 1946*  
 (month) (day) (year)

Cemetery or crematory *Oak Hill Cemetery*

Location *Garadonings, Md.*

18. Funeral director *M. E. Eickhom*

Address *Garadonings, Md.*

19. *June 13, 1946* Dr. *E. Donigan*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *June 10, 1946* at *6:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*June 2nd, 1946* to *June 9, 1946*

and that I last saw him alive on *June 9, 1946*

Immediate cause of death *Tuberculosis of spine*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Henry W. Hodges* M. D. or Other

Address *Lawsonburg, Md.* Date signed *June 14, 1946*

MARGIN RESERVED FOR BINDING

VS A15 9-45-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 15 1946  
BUREAU V.S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 05596 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred:

Sylvan RetreatHow long in hospital or institution? 4 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 630 1/2 Lincoln St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary A. Willard

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Peter Willard

7. Birth date of deceased (mo., day, yr.)

Nov. 26 1857

8. (c) If alive, give age years

8. AGE: Years 88 Months 6 Days 9 If less than one day hrs. min.

9. Birthplace

Johnstown Pa.  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

none

MOTHER

FATHER

12. Name

Wm. Lloyd

13. Birthplace

Pa

14. Maiden name

Martha Willard

15. Birthplace

Pa

16. Informant

Mrs Helen Voit

Address

Cumberland

17. Burial

St Lukes Cem.

Cemetery or crematory

Cumberland

Location

Louis Stein Pae

18. Funeral director

Cumberland

Address

Cumberland

19. Date rec'd by registrar

June 7 1946J. P. Franklin, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1946 at 6 P.

21. I CERTIFY that death occurred on the date above stated; that (attended deceased from

July 1 1941 to June 5 1946and that I last saw him alive on June 4 1946

Immediate cause of death

Broncho-Pneumonia

DURATION

3 days

Due to

Fracture of right

Due to

Fell out of bed

Other conditions

None

RECEIVED

JUN 11 1946

BUREAU V.S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 728

## CERTIFICATE OF DEATH

05597

Reg. Dist. No. 4

### 1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

207 Carrol St.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Carrol St.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Thomas William Willetts

### 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Hannah Whitefield

Willetts

8.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 21, 1875

8. AGE: Years Months Days If less than one day

71

1

7

hrs. min.

9. Birthplace England

(Town, county, and state)

10. Usual occupation Retired Janitor

11. Industry or business Allegany High School

12. Name Francis Willetts

13. Birthplace England

14. Maiden name Frances

15. Birthplace England

16. Informant Mr. Earl Willetts

Address LaVale Cumberland, Md.

17. Burial July 1, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. July 1, 1946 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1946, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 to June 46

and that I last saw him alive on June 28, 1946

Immediate cause of death acute cardiac failure

mitral stenosis

Due to general anoxemia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lyle R. Everhart M.D.

Address 31 Greene St Date signed 7/1-46

M. D. or other

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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RECEIVED

JUL 5 1946

BUREAU V.S.

DR. HODGES

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hrs. 4 mins.

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 10 HOURS 4 MINS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 812 MARYLAND AVENUE  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

BABY BOY WILSON

## 3. (b) Social Security Number

None

## 4. Sex

MALE

## 5. Color of face

WHITE

## 6. (a) Single, married, widowed, or divorced

SINGLE

## 8. (b) Name of husband or wife

8. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

JUNE 14, 1946

## 8. AGE:

Years

Months

Days

If less than one day

10 hrs. 4 min.

9. Birthplace... CUMBERLAND, MARYLAND  
(Town, county, and state)

10. Usual occupation... NEW BORN

## 11. Industry or business

## 12. Name

FRANKLIN, WILSON

## 13. Birthplace

MARYLAND

## 14. Maiden name

FRANCES SNOEBERGER

## 15. Birthplace

MARYLAND

16. Informant... MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

## 17. Burial, cremation, or removal

Cremation

Date thereof June 16, 1946  
(month) (day) (year)

## 18. Location

Memorial Hospital

## 19. Funeral director

Same as above

## 20. Address

## 21. Date rec'd by registrar

June 16, 1946

J. P. Franklin, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... JUNE 15, 1946, at 8:50A M

21. CERTIFY that death occurred on the date above stated; that it attended deceased from

June 15, 1946, to June 15, 1946

and that I last saw him alive on

June 15, 1946

Immediate cause of death

Maternal toxemia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Cumberland, Md

M. D. or other

Address

Date signed 6/16/46

MARGIN RESERVED FOR BINDING

VS A15

9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 25 1946

BUREAU VS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (272)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 years  
Hospital, institution, or street address where death occurred:  
Memorial Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 508 Linden St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Cyril Yost

3. (b) Social Security Number

232-10-0372

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anne E. Yost

7. Birth date of deceased (mo., day, yr.) July 4, 1903 6. (c) If alive, give age 40 years

8. AGE: Years 42 Months 11 Days 13 If less than one day  
.....hrs. ....min.

9. Birthplace Morgan Co., W. Va.  
(Town, county, and state)

10. Usual occupation line man

11. Industry or business Western Union Telegraph Co.

12. Name Joseph W. Yost

13. Birthplace Morgan Co., W. Va.

14. Maiden name Mary A. Allen

15. Birthplace W. Va.

16. Informant Mrs. Anne E. Yost

Address 508 Linden St., Cumberland, Md

17. Burial Date thereof June 20 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Tabor Cemetery

Location 6 mi. south of Berkeley Springs, W. Va.

18. Funeral director John J. Hester

Address Cumtland, Pa.

19. June 19, 1946 J. P. Franklin M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 46 3.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 9 19 46 to June 17 19 46  
and that I last saw him alive on June 16 19 46

Immediate cause of death  
Severe Cerebral congestion DURATION 12 hrs

Due to Convulsions about 6 hrs

Due to presistent vomiting 1 week

Other conditions Acute infectious cholecystitis 1 week  
(Include pregnancy within 3 months of death)

Major findings of operations  
.....Date of op. ....

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or other

Address 125 Bedford St. Date signed 6-17-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 22 1946  
BUREAU OF S.